

13132

13158

FOR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Pages 1 and 2 should be retained by the hospital or attending physician.

FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filled with the State Board of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be returned by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Board of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND
CERTIFICATE OF DEATH

13159

13133

1. PLACE OF DEATH a. COUNTY <u>Wicomico</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>MARYLAND</u> b. COUNTY <u>Worcester</u>					
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>SALISBURY</u>				c. LENGTH OF STAY IN 1b <u>10 days</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>NEWARK</u>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>PENINSULA GENERAL HOSPITAL</u>				d. STREET ADDRESS <u>ROUTE # 1</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First <u>DAISY</u> Middle <u>A</u> Last <u>ALLEN</u>				4. DATE OF DEATH Month <u>NOVEMBER</u> Day <u>16</u> Year <u>1960</u>					
5. SEX <u>FEMALE</u>		6. COLOR OR RACE <u>NEERO</u>		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>8-9-1897</u>			
9. AGE (In years last birthday) <u>63</u> yrs.		IF UNDER 1 YEAR Months <u>6</u> Days <u>16</u> Hours <u>0</u> Min. <u>0</u>		IF UNDER 24 HRS. Months <u>0</u> Days <u>0</u> Hours <u>0</u> Min. <u>0</u>					
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>HOUSE WIFE</u>				10b. KIND OF BUSINESS OR INDUSTRY <u>HOME</u>		11. BIRTHPLACE (State or foreign country) <u>MARYLAND</u>			
12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>									
13. FATHER'S NAME <u>ISMAH AYRE</u>				14. MOTHER'S MAIDEN NAME <u>JENNIE ADASSEY</u>					
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>NO</u>				16. SOCIAL SECURITY NO. <u>NO</u>		17. INFORMANT Address <u>MR. JACK ALLEN, NEWARK, MD - RT # 1</u>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>416X</u> DUE TO <u>Consecutive Heart Failure</u> <u>Thrombotic Heart Disease</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <u>Upper GI Bleeding</u> DUE TO <u>Gastric Ca.</u> (c) <u>Gastric Ca.</u>								INTERVAL BETWEEN ONSET AND DEATH <u>73 wks</u> <u>73 wks</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>Pneumonia</u>								19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. <u>19</u>				20d. INJURY OCCURRED While o. m. p. m. <input type="checkbox"/> Not while o. m. p. m. <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)			
20f. (City or town) (County) (State)									
21. I certify that (I) (this hospital) attended the deceased from <u>11-6-1960</u> to <u>11-16-1960</u> that (I) (we) last saw the deceased alive on <u>11-16-1960</u> and that death occurred at <u>3 P.M.</u> from the causes and on the date stated above.									
22a. SIGNATURE <u>Francis Allen</u>				M.D. ATTENDING PHYS. <input type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input checked="" type="checkbox"/>		22b. DATE SIGNED <u>11-16-60</u>			
22c. PHYSICIAN'S NAME (Type) <u>P. G. H. Salisbury, Md.</u>				22d. ADDRESS <u>P. G. H. Salisbury, Md.</u>					
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>BURIAL</u>		23b. DATE THEREOF <u>11-19-60</u>		23c. NAME OF CEMETERY OR CREMATORY <u>EVERGREEN Cem.</u>		23d. LOCATION (City, town, or county) (State) <u>BERLIN, MD</u>			
24. FUNERAL DIRECTOR'S SIGNATURE <u>Thornton B. Jolley</u>				ADDRESS <u>Salisbury, Md.</u>		25a. REC'D BY REGISTRAR DATE <u>NOV 28 '60</u>			
						25b. REGISTRAR'S SIGNATURE <u>Charles S. Kline</u>			

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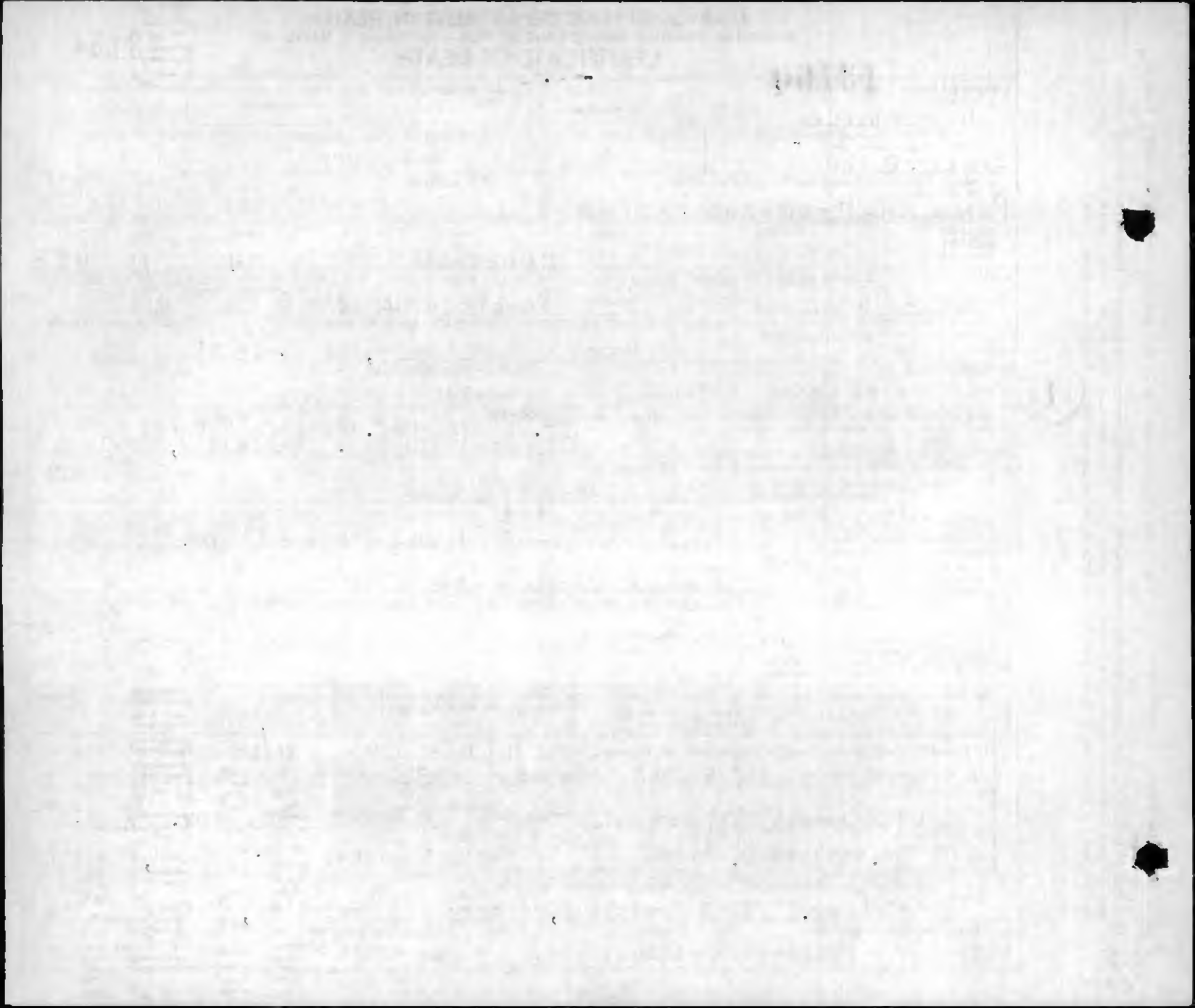
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[Faint, mostly illegible handwritten text, possibly bleed-through from the reverse side of the page. Some words like "and", "the", "of", "in" are visible.]

1. PLACE OF DEATH a. COUNTY Wicomico		b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Salisbury		c. LENGTH OF STAY IN 1b 12		d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION PENINSULA GENERAL HOSPITAL		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>					
3. NAME OF DECEASED (Type or print) DAWN		First MARIE		Middle ANDERSON		Last ANDERSON		4. DATE OF DEATH Month 11 Day 16 Year 1960					
5. SEX FEMALE		6. COLOR OR RACE WHITE		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH NOVEMBER 14 1960		9. AGE (In years last birthday) 0 yrs.		IF UNDER 1 YEAR Months 0 Days 2 Hours 2 Min.		IF UNDER 24 HRS.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) None		10b. KIND OF BUSINESS OR INDUSTRY None		11. BIRTHPLACE (State or foreign country) Salisbury, Md (Hospital)		12. CITIZEN OF WHAT COUNTRY? U S A							
13. FATHER'S NAME Charles George Anderson		14. MOTHER'S MAIDEN NAME Sylvia Mae Carey											
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) No		16. SOCIAL SECURITY NO. N/A		17. INFORMANT Mr. Charles Geo. Anderson (Father)		Address 115 Benjamin Ave. Salisbury, Maryland							
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) 7-62-5 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Respiratory failure (c) Intracranial Hemorrhage + edema Fetal Anoxia												INTERVAL BETWEEN ONSET AND DEATH	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) atelectasis												19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) N/A		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) N/A											
20c. TIME OF INJURY Month N/A Day 19 Year 1960 Hour N/A a. m. N/A p. m. N/A		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) N/A		20f. (City or town) N/A		(County) N/A		(State) N/A			
21. I certify that (I) (this hospital) attended the deceased from 11/14/1960 to 11/16/1960 that (I) (we) last saw the deceased alive on 11/16/1960 , and that death occurred at 3:47 M, from the causes and on the date stated above.													
22a. SIGNATURE William C. Morgan		M.D.		ATTENDING PHYS. <input checked="" type="checkbox"/>		MED. DIRECTOR <input type="checkbox"/>		STAFF PHYS. <input type="checkbox"/>		22b. DATE SIGNED Nov. 17/1960			
22c. PHYSICIAN'S NAME (Type) Dr. William C. Morgan				22d. ADDRESS Medical Center Salisbury, Maryland									
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE THEREOF Nov. 17/1960		23c. NAME OF CEMETERY OR CREMATORY Fruitland Cemetery		23d. LOCATION (City, town, or county) Fruitland, Maryland		(State) Maryland					
24. FUNERAL DIRECTOR'S SIGNATURE HOLLOWAY & COMPANY		ADDRESS SALISBURY MARYLAND		25a. REC'D BY REGISTRAR DATE NOV 21 '60		25b. REGISTRAR'S SIGNATURE Arthur S. Thomas							

VR A1541
ISM 9/59

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Board of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

VR A15 (4)
15M 9/59

DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND
CERTIFICATE OF DEATH

13135

13161

1. PLACE OF DEATH a. COUNTY Wicomico MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Wicomico	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Salisbury		c. LENGTH OF STAY IN 1b 4 yrs.	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Centenary Dr.		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First JAMES Middle ALLEN Last BAILEY		4. DATE OF DEATH Month November Day 18 Year 19 60	
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH September 4, 1871
9. AGE (In years lost birthday) 89 yrs.		10. IF UNDER 1 YEAR Months 0 Days 0 Hours 0 Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Seafood, Ret.		10b. KIND OF BUSINESS OR INDUSTRY Retail & Wholesale	
11. BIRTHPLACE (State or foreign country) Maryland		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME Oliver B ailey		14. MOTHER'S MAIDEN NAME Eliza Marsch	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No		16. SOCIAL SECURITY NO. None	
17. INFORMANT Clendon Bailey		Address Salisbury, Maryland	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Uremia DUE TO Chronic Pyelonephritis Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) Chronic Pyelonephritis (c) Chronic Pyelonephritis PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) INTERVAL BETWEEN ONSET AND DEATH days months			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. 19 p. m.		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from 1954 , 19 19 to 18 Nov , 19 60 , that (I) (we) last saw the deceased alive on 17 Nov , 19 60 and that death occurred at 10 A.M. from the causes and on the date stated above.			
22a. SIGNATURE Earl L. Royer		22b. DATE SIGNED 11-19-60	
22c. PHYSICIAN'S NAME (Type) Earl L. Royer		22d. ADDRESS 407 Camden Ave., Salisbury, Maryland	
23a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL		23b. DATE THEREOF NOV. 20. 1960	
23c. NAME OF CEMETERY OR CREMATORY Asbury Church Cemetery		23d. LOCATION (City, town, or county) (State) MT. Vernon, Maryland	
24. FUNERAL DIRECTOR'S SIGNATURE Hill & Johnson Co. Salisbury, Maryland		25a. REC'D BY REGISTRAR NOV 22 '60	
25b. REGISTRAR'S SIGNATURE Colbert L. Thomas			

George C. Miller

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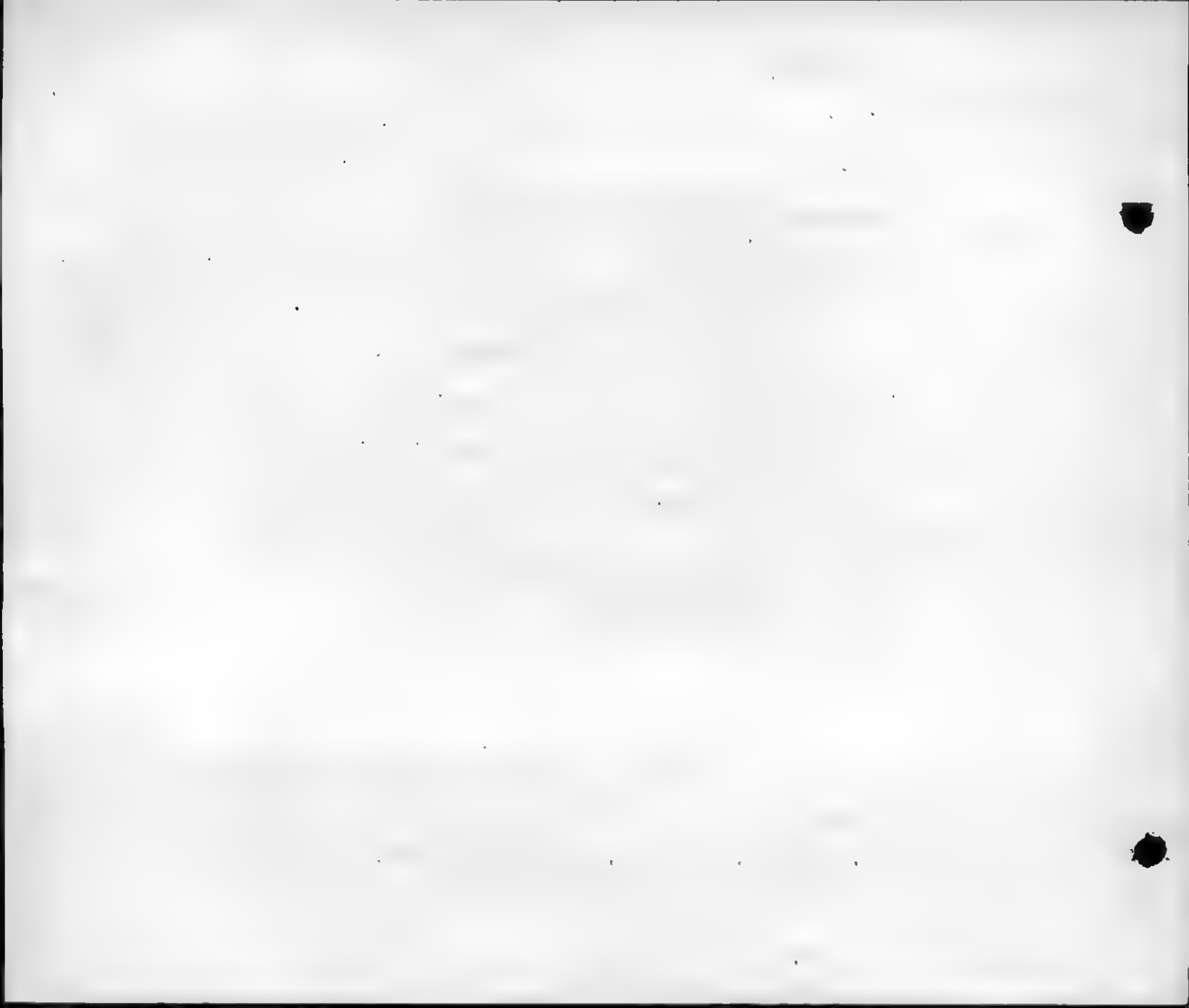
VR A15 (4)
1SM M/59

13163

13137

1. PLACE OF DEATH a. COUNTY <u>Wicomico</u> <u>MARYLAND</u>		2. USUAL RESIDENCE (Where deceased lived if institution Residence before admission) a. STATE <u>Virginia</u> b. COUNTY <u>✓</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Salisbury</u>		c. LENGTH OF STAY IN 1b <u>5 DAYS</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Peninsula General Hospital</u>		d. STREET ADDRESS <u>722...</u>	
3. NAME OF DECEASED (Type or print) First <u>Jack</u> Middle <u>BASS-</u> Last <u>BOAT</u>		4. DATE OF DEATH Month <u>November</u> Day <u>13</u> Year <u>1960</u>	
5. SEX <u>MALE</u>	6. COLOR OR RACE <u>Wh</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>MAY 29, 1901</u>
9. AGE (In years last birthday) <u>59</u> yrs		10. IF UNDER 1 YEAR Months <u> </u> Days <u> </u> Hours <u> </u> Min <u> </u>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Self-Employed</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Industrial Machinery</u>	
11. BIRTHPLACE (State or foreign country) <u>Jerusalem</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>ABRAHAM MOSES</u>		14. MOTHER'S MAIDEN NAME <u>SARAH KOVEN</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u> </u>		16. SOCIAL SECURITY NO. <u> </u>	
17. INFORMANT <u>Rabbi J. Washer</u>		Address <u>125 Cherry St. A. A. TENECK, N.J.</u>	
18. CAUSE OF DEATH [Enter any one cause per line for (a), (b), and (c)] PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <u>Myocardial Infarct, acute</u> DUE TO <u> </u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u> </u> DUE TO <u> </u> (c) <u> </u> PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u> </u> 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18) <u> </u>	
20c. TIME OF INJURY Month, Day, Year Hour o. m. <u> </u> p. m. <u> </u> 19 <u> </u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <u> </u>		20f. (City or town) (County) (State) <u> </u>	
21. I certify that (I) (this hospital) attended the deceased from <u>11-8-1960</u> to <u>11-13-1960</u> that (I) (we) last saw the deceased alive on <u>11-13-1960</u> , and that death occurred at <u>8 P.M.</u> from the causes and on the date stated above.			
22a. SIGNATURE <u>Dr. Wilber R. Ellis, Jr.</u>		22b. DATE SIGNED <u>11-15-60</u>	
22c. PHYSICIAN'S NAME (Type) <u>Dr. Wilber R. Ellis, Jr.</u>		22d. ADDRESS <u>Salisbury, Maryland</u>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>BURIAL</u>		23b. DATE THEREOF <u>11-15-60</u>	
23c. NAME OF CEMETERY OR CREMATORY <u>Cedar Park Cemetery</u>		23d. LOCATION (City, town, or county) (State) <u>PARANUS N.J.</u>	
24. FUNERAL DIRECTOR'S SIGNATURE <u>Hill & Johnson Co. Salisbury, Maryland</u>		25. REC'D BY REGISTRAR DATE <u>NOV 16 '60</u>	
25b. REGISTRAR'S SIGNATURE <u>Arthur S. Krand</u>			

Norman T. Baker



MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND

13164 CERTIFICATE OF DEATH

13168

1. PLACE OF DEATH a. COUNTY: <u>WICOMICO</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE: <u>MARYLAND</u> b. COUNTY: <u>WICOMICO</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>SALISBURY</u>				c. LENGTH OF STAY IN 1b			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>PENINSULA GENERAL HOSPITAL</u>				d. STREET ADDRESS <u>1 DELMAR Rd.</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First: <u>Baby Girl</u> Middle: <u>BENNETT</u> Last: <u>BENNETT</u>				4. DATE OF DEATH Month: <u>NOVEMBER</u> Day: <u>6</u> Year: <u>1960</u>			
5. SEX <u>FEMALE</u>	6. COLOR OR RACE <u>WHITE</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>NOVEMBER 5, 1960</u>		9. AGE (In years last birthday) yes <u>2</u> Min <u>52</u>	IF UNDER 1 YEAR Months <u> </u> Days <u> </u> Hours <u> </u> Min <u> </u>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) <u>MARYLAND</u>		12. CITIZEN OF WHAT COUNTRY?	
13. FATHER'S NAME <u>UNKNOWN</u>				14. MOTHER'S MAIDEN NAME <u>MARGIE BENNETT</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown)		16. SOCIAL SECURITY NO.		17. INFORMANT <u>JAMES Phoebeus, DELMAR Rd., SALISBURY, Md.</u>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c)] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>PREMATURITY</u> 761-55 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>PREMATURE SEPARATION 1 MONTH</u> DUE TO (c) <u> </u>							INTERVAL BETWEEN ONSET AND DEATH
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)							19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour a. m. <u> </u> p. m. <u> </u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from <u>11-5-1960</u> to <u>11-6-1960</u> , that (I) (we) last saw the deceased alive on <u>11-6-1960</u> , and that death occurred at <u>4:30</u> M. from the causes and on the date stated above							
22a. SIGNATURE <u>Robert Lee Barker</u>				M. D. ATTENDING PHYS <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS <input type="checkbox"/>		22b. DATE SIGNED <u>11-6-60</u>	
22c. PHYSICIAN'S NAME (Type)				22d. ADDRESS <u>SALISBURY, Md.</u>			
23a. BURIAL, CREMATION, REMOVAL (Specify)		23b. DATE THEREOF		23c. NAME OF CEMETERY OR CREMATORY		23d. LOCATION (City, town, or county) (State)	
<u>BURIAL</u>		<u>11-6-1960</u>		<u>WICOMICO MEM. PARK</u>		<u>SALISBURY, Md.</u>	
24. FUNERAL DIRECTOR'S SIGNATURE <u>Thomas H. Wallace</u>				ADDRESS <u>Salisbury, Md.</u>		25a. RECEIVED BY REGISTRAR DATE <u>NOV 9 '60</u>	
						25b. REGISTRAR'S SIGNATURE <u>S. Traub</u>	



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be returned by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filled with the State Board of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

VR AIS (4)
15M 9/59

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND
CERTIFICATE OF DEATH

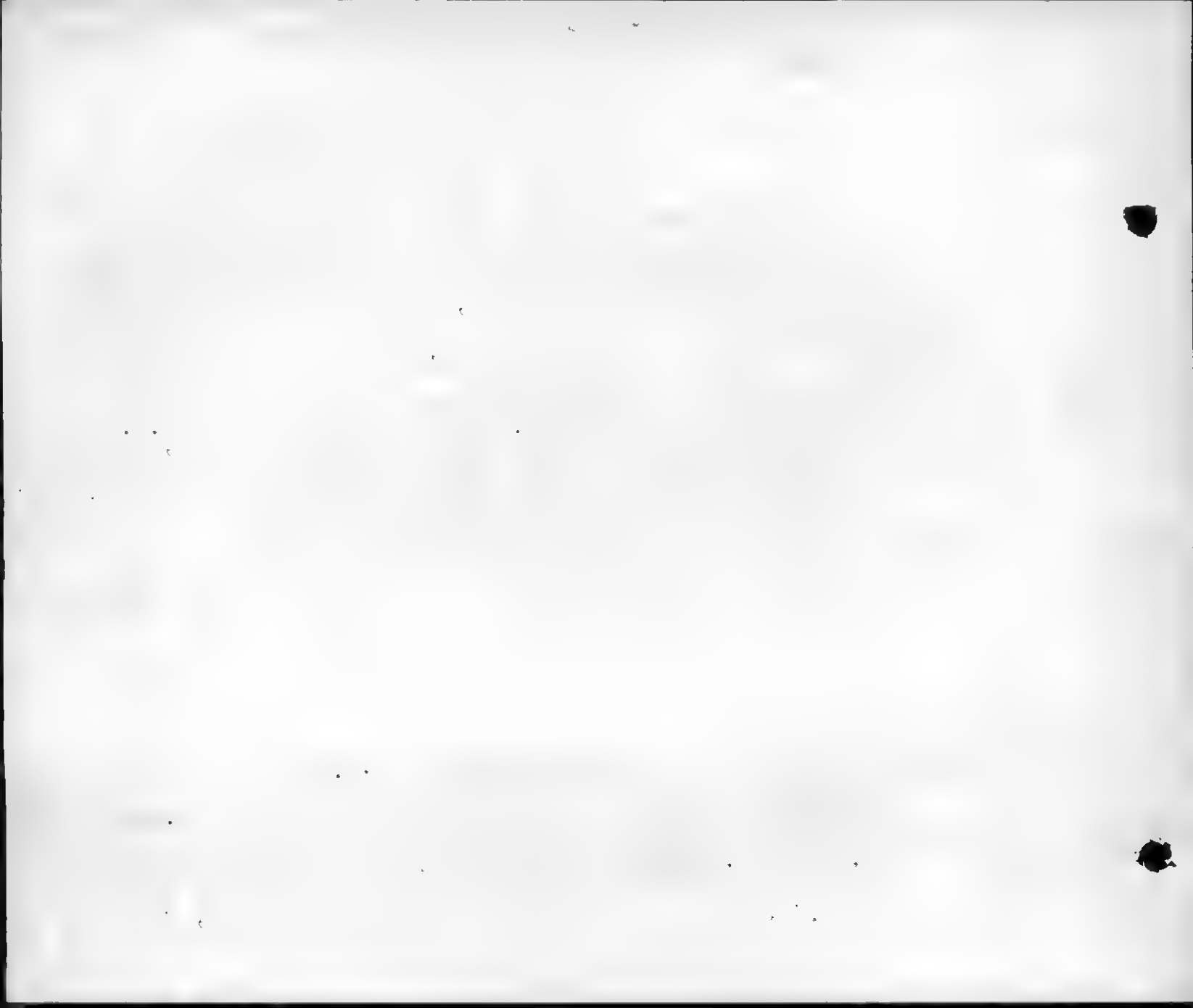
13165

13139

1. PLACE OF DEATH a. COUNTY <u>Wicomico</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived If institution: Residence before admission) a. STATE <u>MARYLAND</u> b. COUNTY <u>Wicomico</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>SALISBURY</u>				c. LENGTH OF STAY IN 1b 12 <u>SALISBURY</u>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>PENINSULA GENERAL HOSPITAL</u>				d. STREET ADDRESS <u>Delmar Road</u>		e. RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <u>Baby Boy</u> Middle <u>BENNETT</u> Last <u>BENNETT</u>				4. DATE OF DEATH Month <u>NOVEMBER</u> Day <u>6</u> Year <u>1960</u>			
5. SEX <u>MALE</u>		6. COLOR OR RACE <u>WHITE</u>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>NOVEMBER 5, 1960</u>	
9. AGE (In years last birthday) <u>2</u> yrs.		F UNDER 1 YEAR Months <u>2</u> Days <u>5</u>		IF UNDER 24 HRS Hours <u>2</u> Min <u>5</u>			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)				10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) <u>MARYLAND</u>	
12. CITIZEN OF WHAT COUNTRY?							
13. FATHER'S NAME <u>UNKNOWN</u>				14. MOTHER'S MAIDEN NAME <u>MARGIE BENNETT</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown)				16. SOCIAL SECURITY NO (If yes, give war or dates of service)		17. INFORMANT Address <u>JAMES Phoebe, Delmar Rd, Salisbury, Md.</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>PREMATURITY</u> DUE TO <u>701.3</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>PREMATURE SEPARATION PLACENTA</u> DUE TO (c)							INTERVAL BETWEEN ONSET AND DEATH
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)							19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18)			
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from <u>11-5</u> , 19 <u>60</u> , to <u>11-6</u> , 19 <u>60</u> , that (I) (we) last saw the deceased alive on <u>11-6</u> , 19 <u>60</u> , and that death occurred at <u>4</u> M, from the causes and on the date stated above							
22a. SIGNATURE <u>Robert Lee Waker</u> M.D.				ATTENDING PHYS <input type="checkbox"/> MED DIRECTOR <input type="checkbox"/> STAFF PHYS <input type="checkbox"/>		22b. DATE SIGNED <u>11-6-60</u>	
22c. PHYSICIAN'S NAME (Type) <u>Salisbury, Md.</u>				22d. ADDRESS			
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>BURIAL</u>		23b. DATE THEREOF <u>11-6-1960</u>		23c. NAME OF CEMETERY OR CREMATORY <u>Wicomico MEM. PARK</u>		23d. LOCATION (City, town, or county) (State) <u>Salisbury Md.</u>	
24. FUNERAL DIRECTOR'S SIGNATURE <u>Thomas Salas</u>				25a. REC'D BY REGISTRAR DATE <u>NOV 9 '60</u>		25b. REGISTRAR'S SIGNATURE <u>Arthur S. Fuma</u>	

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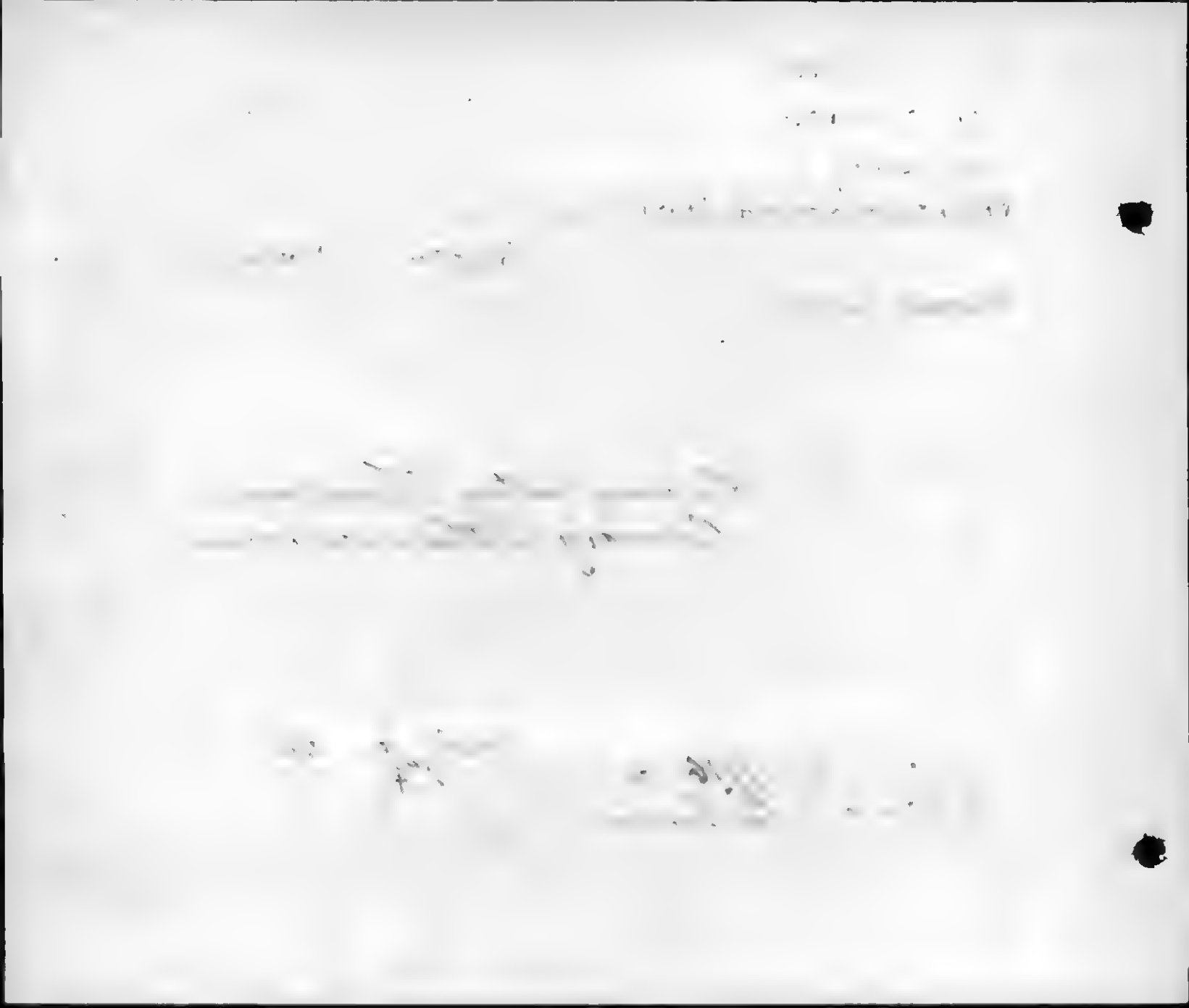


13166

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND
CERTIFICATE OF DEATH

13141

1. PLACE OF DEATH a. COUNTY WICOMICO				2. USUAL RESIDENCE (Where deceased lived If institution Residence before admission) a. STATE MARYLAND b. COUNTY WICOMICO			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) SALISBURY				c. LENGTH OF STAY IN 1b 3 WKS			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION PENINSULA GENERAL HOSPITAL				e. STREET ADDRESS 427 Somerset			
3. NAME OF DECEASED (Type or print) First CORA Middle REBECCA Last BOOTH				4. DATE OF DEATH Month NOVEMBER Day 17 Year 1960			
5. SEX FEMALE		6. COLOR OR RACE WHITE		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH JULY 28, 1874	
9. AGE (In years last birthday) 86 yrs.		10. IF UNDER 1 YEAR Months 8 Days 17 Hours 17 Min 17		11. IF UNDER 24 HRS Months 8 Days 17 Hours 17 Min 17		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) HOUSE WIFE				10b. KIND OF BUSINESS OR INDUSTRY OWN HOME			
11. BIRTHPLACE (State or foreign country) MARYLAND				12. CITIZEN OF WHAT COUNTRY? U.S.A.			
13. FATHER'S NAME JOHN S. JONES				14. MOTHER'S MAIDEN NAME MARTHA WHITE			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes no or unknown) NO				16. SOCIAL SECURITY NO NONE			
17. INFORMANT Geo. Booth, Salisbury, Md.				Address			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c)] PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) Coronary Artery Thrombosis Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) Coronary Atherosclerosis (c) 14 days INTERVAL BETWEEN ONSET AND DEATH 14 days							
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH, BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)				20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18)			
20c. TIME OF INJURY Month, Day, Year Hour 0 m. 19 p. m.				20d. INJURY OCCURRED While <input type="checkbox"/> at work <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/>			
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)				20f. (City or town) (County) (State)			
21. I certify that (I) (this hospital) attended the deceased from 10/28 to 11/17 19 60 that (I) (we) lost saw the deceased alive on 11/16 19 60 , and that death occurred at 11:15 A.M. from the causes and on the date stated above							
22a. SIGNATURE David J. Gilmore				22b. DATE SIGNED 11-17-1960			
22c. PHYSICIAN'S NAME (Type) DAVID J. GILMORE				22d. ADDRESS Medical Center Salisbury, MD			
23a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL				23b. DATE THEREOF 11-18-1960			
23c. NAME OF CEMETERY OR CREMATORY PARSONS CEMETERY				23d. LOCATION (City, town or county) (State) SALISBURY, MARYLAND			
24. FUNERAL DIRECTOR'S SIGNATURE Hill & Johnson				25a. REC'D BY REGISTRAR NOV 18 '60			
25b. REGISTRAR'S SIGNATURE Norman T. Baber				25c. REGISTRAR'S SIGNATURE William L. Fennell			



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filled with the State Board of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

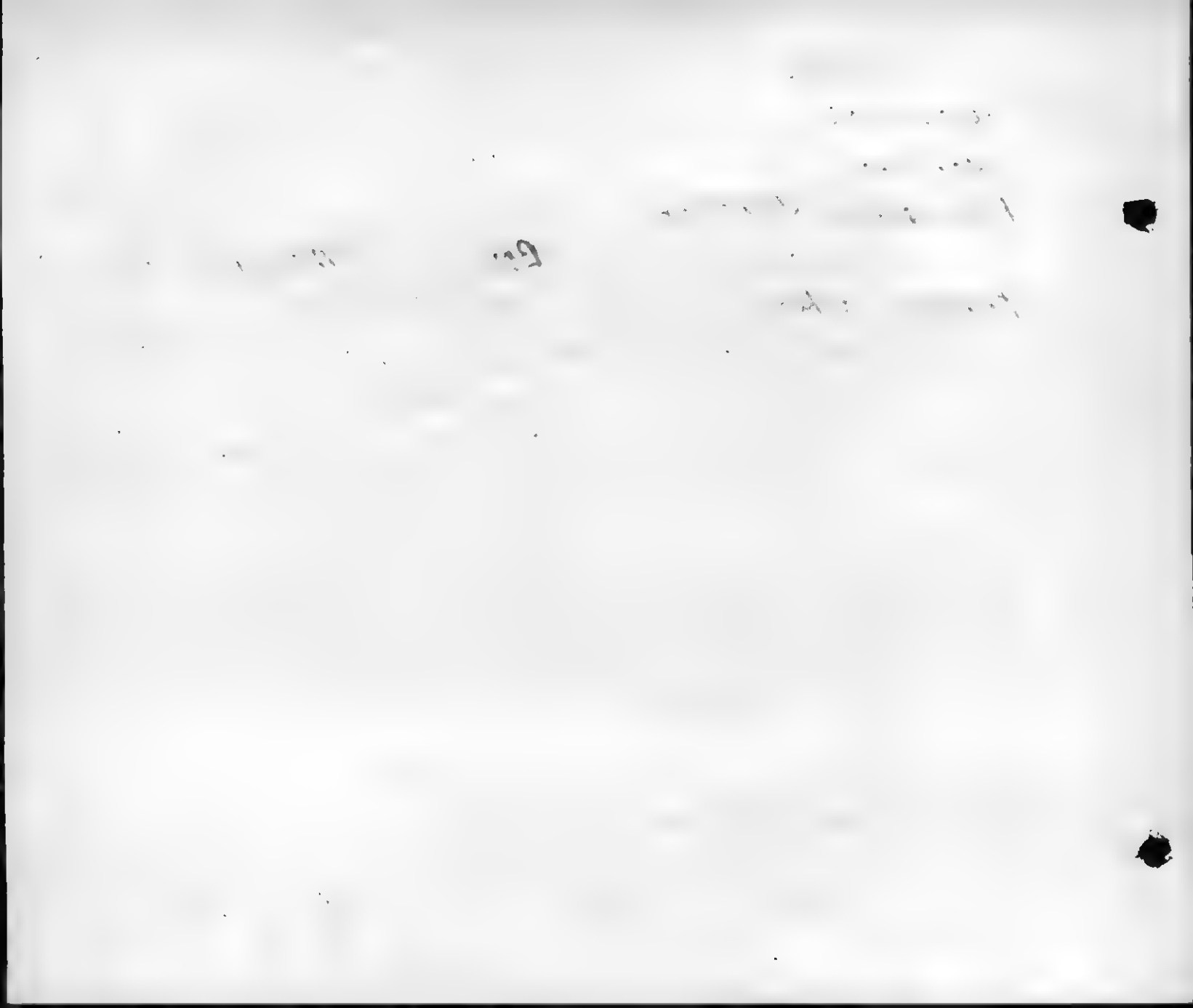
MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND

13167

CERTIFICATE OF DEATH
Item 7 Film 6-15 11-28-60 et

13142

1. PLACE OF DEATH a. COUNTY <u>Wicomico</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution; Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Caroline</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Salisbury</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Ridgely</u>	
d. NAME OF HOSPITAL (If not a hospital, give street address) OR INSTITUTION <u>Peninsula General</u>		d. STREET ADDRESS <u>05X-1</u>	
3. NAME OF DECEASED (Type or print) First <u>BEATRICE</u> Middle <u>Bower</u> Last <u>Bower</u>		4. DATE OF DEATH Month <u>November</u> Day <u>20</u> Year <u>1960</u>	
5. SEX <u>Female</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>Unknown</u>
9. AGE (In years last birthday) <u>63</u> yrs		IF UNDER 1 YEAR Months Days Hours Min	
10a. USUAL OCCUPATION (Give kind of work done during most of work no life, even if retired) <u>TEACHER</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Elementary</u>	
11. BIRTHPLACE (State or foreign country) <u>Maryland</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>	
13. FATHER'S NAME <u>Wesley Bower</u>		14. MOTHER'S MAIDEN NAME <u>JENNIE GREEN</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown) <u>No</u>		16. SOCIAL SECURITY NO. <u>11-220-1960</u>	
17. INFORMANT <u>Kyrie Hanesy Hessler, Nurse, Hdr, Md.</u>		Address <u>11-21-60</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c)] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Pneumonia</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost (b) <u>Heart disease</u> DUE TO (c) <u>arteriosclerosis</u>		INTERVAL BETWEEN ONSET AND DEATH <u>10-21-60</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18)	
20c. TIME OF INJURY Month, Day Year Hour a.m. p.m. <u>19</u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (1) (this hospital) attended the deceased from <u>11-20-1960</u> to <u>11-21-1960</u> that (1) (we) last saw the deceased alive on <u>11-21-1960</u> , and that death occurred at <u>6:00</u> A.M. from the causes and on the date stated above.			
22a. SIGNATURE <u>William R. Ellis</u> M.D.		22b. DATE SIGNED <u>11-21-60</u>	
22c. PHYSICIAN'S NAME (Type)		22d. ADDRESS	
23a. BURIAL, CREMATION, REMOVAL (Specify)		23b. DATE THEREOF	
23c. NAME OF CEMETERY OR CREMATORY		23d. LOCATION (City, town, or county) (State)	
24. FUNERAL DIRECTOR'S SIGNATURE <u>George Moore Brown, Denton, Md.</u>		25a. REC'D BY REGISTRAR DATE <u>NOV 22 1960</u>	
25b. REGISTRAR'S SIGNATURE <u>Arthur S. Thomas</u>			

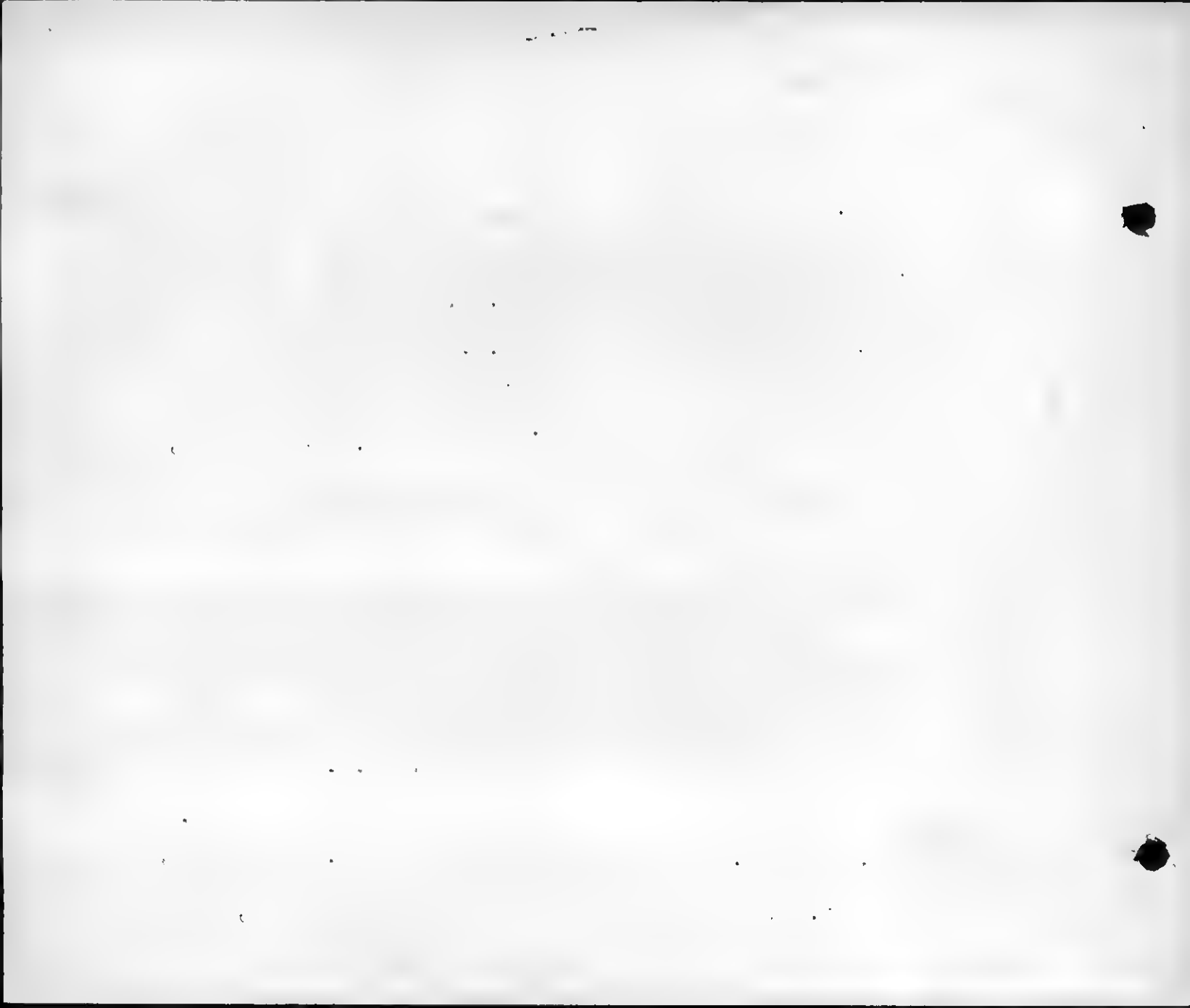


may be retained by the hospital or attending physician.

DO FUNERAL DIRECTOR. After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Board of Health prior to burial, cremation, or removal, and in any event ~~within~~ 72 hours after death.

13143

1 PLACE OF DEATH a. COUNTY Wicomico		MARYLAND		2 USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland		b. COUNTY Wicomico	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Salisbury		c. LENGTH OF STAY IN 1b		d. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Salisbury			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Pen Jen Hospital				e. STREET ADDRESS Spring Hill Road		f. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3 NAME OF DECEASED (Type or print) NANNIE ELLEN BRADLEY		First Middle Last		4. DATE OF DEATH Month Day Year NOVEMBER 7th 1960			
5 SEX Female		6 COLOR OR RACE White		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH Oct. 30, 1882	
9 AGE (In years last birthday) 78 yrs		IF UNDER 1 YEAR Months Days Hours Min		10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired). House work-Retired		10b. KIND OF BUSINESS OR INDUSTRY None	
11. BIRTHPLACE (State or foreign country) R.D.# Delmar, Maryland		12. CITIZEN OF WHAT COUNTRY? U S A		13. FATHER'S NAME Wilson Wright		14. MOTHER'S MAIDEN NAME Annie Holloway	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <input type="checkbox"/> (If yes, give war or dates of service)		16. SOCIAL SECURITY NO.		17. INFORMANT Mrs. Vera Collins (Daughter) 511 Wiley St. - - - - - Sanford, Delaware		Address	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b) and (c)) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Pulmonary Edema 430 DUE TO (b) Antero-sclerotic Heart Disease DUE TO (c)						INTERVAL BETWEEN ONSET AND DEATH	
PART II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)						19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 1B) N/A					
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. N/A 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) N/A		20f. (City or town) (County) (State) N/A	
21 I certify that (I) (this hospital) attended the deceased from 1958 to 11/7/60, 1960, that (I) (we) lost saw the deceased alive on 11/7/60 1960, and that death occurred at 6:00A.M. from the causes and on the date stated above							
22a. SIGNATURE Dr. Andrew C. Mitchell				22b. ADDRESS Nov. 1960		22c. DATE SIGNED 11/7/60	
22d. PHYSICIAN'S NAME (Type) Dr. Andrew C. Mitchell				22e. ADDRESS Nov. 1960			
23a. BLR AL, CREMATION, REMOVAL (Specify)		23b. DATE THEREOF Nov. 10, 1960		23c. NAME OF CEMETERY OR CREMATORY Flemings Cemetery		23d. LOCATION (City, town, or county) (State) Shirlington, Maryland	
24. FUNERAL DIRECTOR'S SIGNATURE HORTOLAY & COMPANY				ADDRESS SALISBURY MARYLAND		25a. REC'D BY REGISTRAR NOV 13 '60	
				25b. REGISTRAR'S SIGNATURE Arthur L. Kraus			



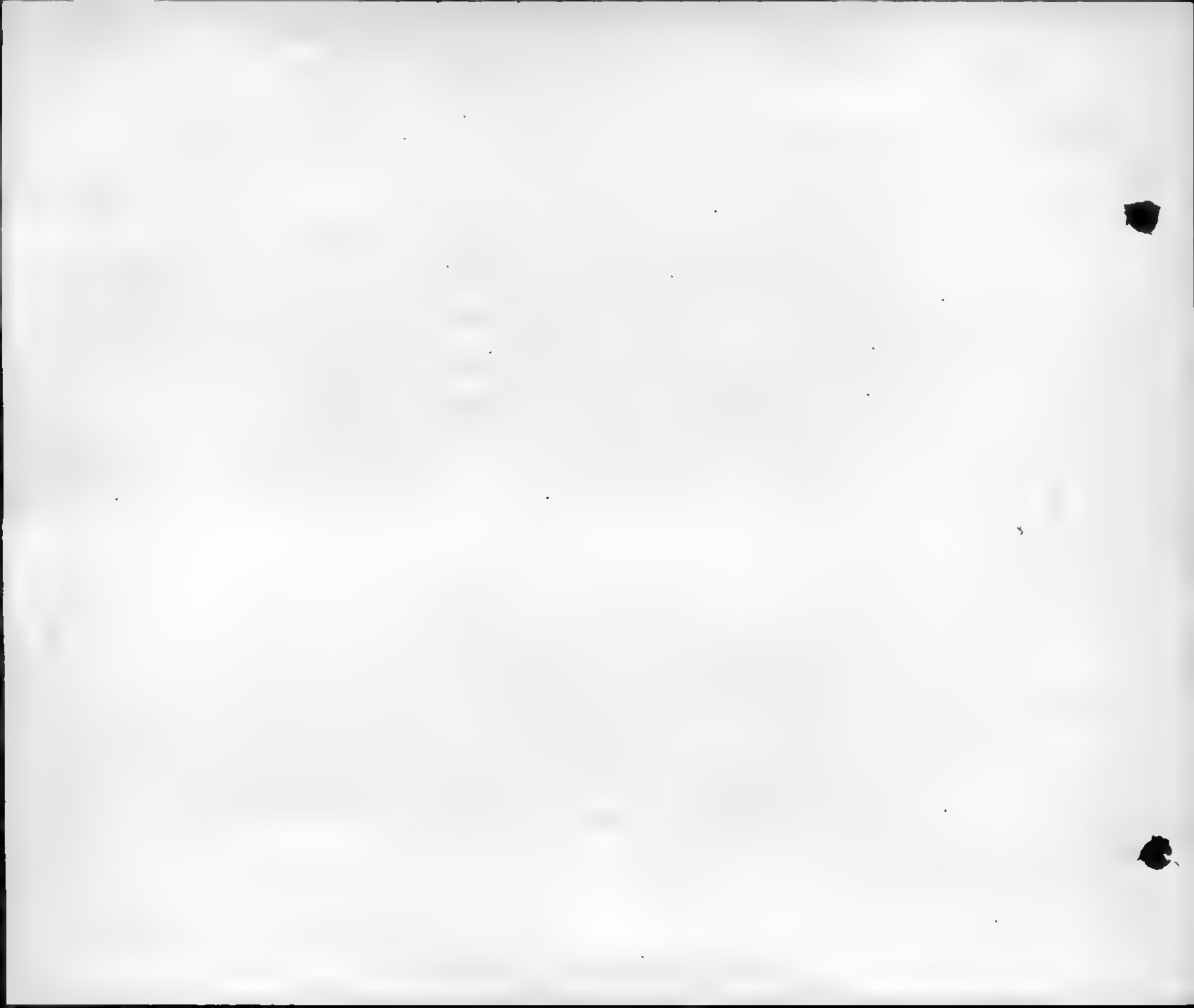
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Board of Health prior to burial, cremation, or removal, at any event, within 72 hours after death.

13169

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND
CERTIFICATE OF DEATH

13144

1. PLACE OF DEATH a. COUNTY <u>Wicomico</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Wicomico</u>			
b. CITY OR TOWN (If outside of corporate limits, write RURAL and give nearest town) <u>SALISBURY</u>				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Salisbury</u>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>PENINSULA GENERAL HOSPITAL</u>				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First Middle Last <u>William P. Bradley</u>				4. DATE OF DEATH Month Day Year <u>NOVEMBER 24 1960</u>			
5. SEX <u>MALE</u>	6. COLOR OR RACE <u>WHITE</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>1914</u>		9. AGE (In years, last birthday) <u>46</u> yrs	IF UNDER 1 YEAR Months Days Hours Min.	IF UNDER 24 HRS Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Farmer</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Farmer</u>		11. BIRTHPLACE (State or foreign country) <u>Maryland</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.</u>	
13. FATHER'S NAME <u>James H. Bradley</u>				14. MOTHER'S MAIDEN NAME <u>Virginia P. Bradley</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>No</u>		16. SOCIAL SECURITY NO. <u>3-12-456789</u>		17. INFORMANT <u>Dr. W. J. P. Smith</u>		Address <u>Salisbury, Md.</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Degenerative Heart Disease</u> <u>422.2</u> DUE TO (b) _____ Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (c) _____ DUE TO (c) _____ PART II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) _____						INTERVAL BETWEEN ONSET AND DEATH <u>2-3 weeks</u>	
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <u>11:24</u> 19 <u>60</u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <u>Home</u>		20f. (City or town) (County) (State) <u>Salisbury, Md.</u>	
21. I certify that (I) (this hospital) attended the deceased from <u>Oct 19, 1960</u> to <u>11:24, 1960</u> that (I) (we) last saw the deceased alive on <u>11:24, 1960</u> , and that death occurred at <u>5:11</u> M. from the causes and on the date stated above							
22a. SIGNATURE <u>W. J. P. Smith</u>				22b. DATE SIGNED <u>11-24-60</u>		22c. PHYSICIAN'S NAME (Type) <u>W. J. P. Smith</u>	
22d. ADDRESS <u>Salisbury, Md.</u>				22e. MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>			
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		23b. DATE THEREOF <u>11-26-60</u>		23c. NAME OF CEMETERY OR CREMATORY <u>Marble Hill</u>		23d. LOCATION (City, town, or county) (State) <u>Salisbury, Md.</u>	
24. FUNERAL DIRECTOR'S SIGNATURE <u>Smith Funeral Home</u>				25a. RECORDING REGISTRAR <u>NOV 28 60</u>		25b. REGISTRAR'S SIGNATURE <u>Arthur S. Thomas</u>	



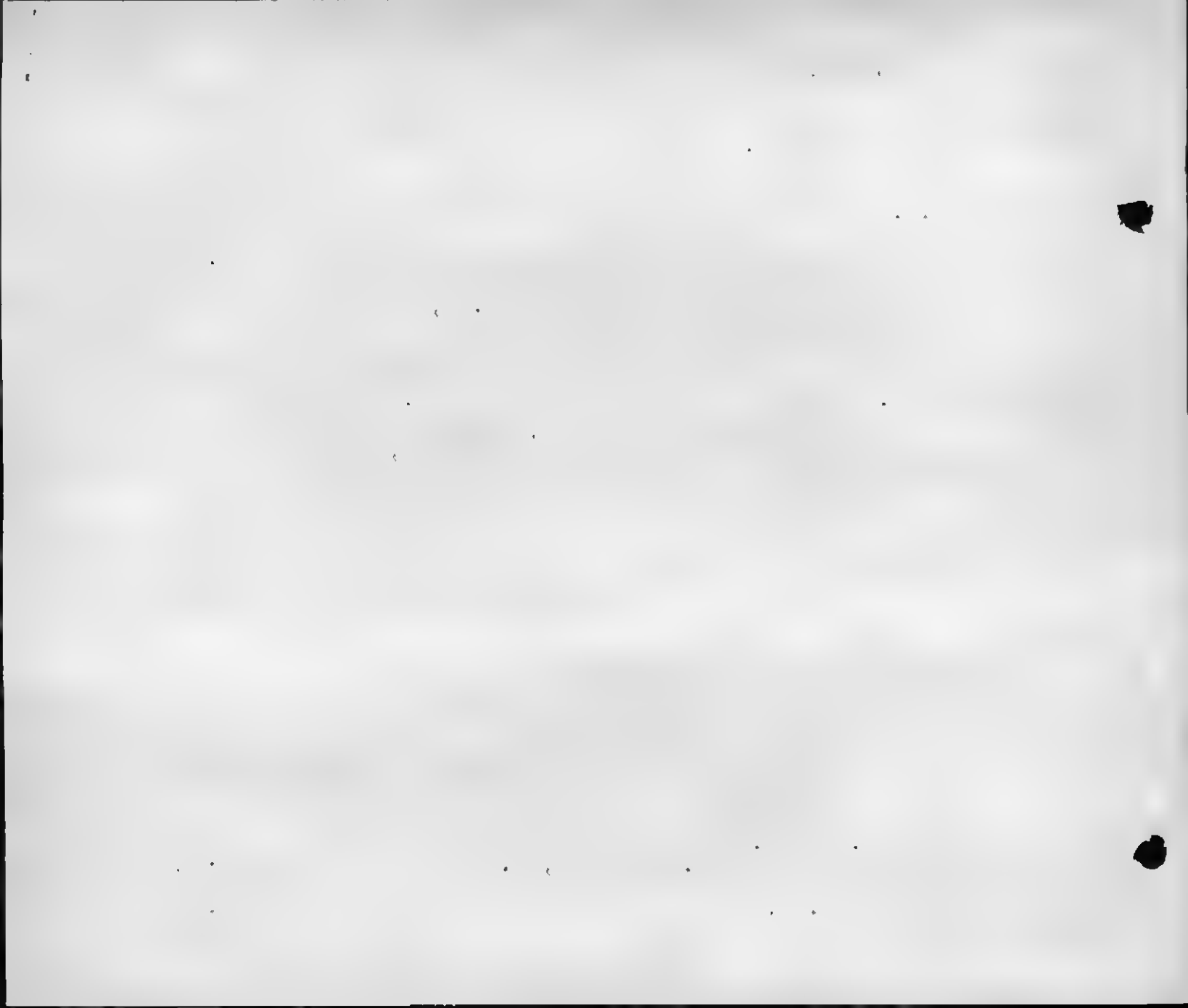
TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If an autopsy is necessary, please execute the certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM-3. Page 5 may be retained for your files.
TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

FOR STATE HEALTH DEPT.

VS. A15ME
5M 7/59

MEDICAL CERTIFICATION

MARYLAND STATE DEPARTMENT OF HEALTH									
Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND									
MEDICAL EXAMINER'S CERTIFICATE OF DEATH									
13170 13145									
1. PLACE OF DEATH a. COUNTY <u>Wicomico</u> b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Salisbury</u> c. LENGTH OF STAY IN 1b <u>MARYLAND</u> d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>D.O.A. at Pen Gen Hospital</u>					2. USUAL RESIDENCE (Where deceased lived, if institution. Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Wicomico</u> c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Salisbury</u> d. STREET ADDRESS <u>Johnson Road</u> e. RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>				
3. NAME OF DECEASED (Type or print) <u>ALICE ELIZABETH CHANDLER</u>		4. DATE OF DEATH <u>NOV. 22 1960</u>		5. SEX <u>Female</u>		6. COLOR OR RACE <u>White</u>		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	
8. DATE OF BIRTH <u>Sept. 24, 1920</u>		9. AGE (In years last birthday) <u>40</u> yrs.		10. IF UNDER 1 YEAR Months <u>8</u>		11. IF UNDER 24 HRS Hours <u>1</u> Min.		12. CITIZEN OF WHAT COUNTRY? <u>U S A</u>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>House Work</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>None</u>		11. BIRTHPLACE (State or foreign country) <u>Wilmington, Delaware</u>		12. CITIZEN OF WHAT COUNTRY? <u>U S A</u>			
13. FATHER'S NAME <u>Thomas P. Steele</u>		14. MOTHER'S MAIDEN NAME <u>Annie V. Malin</u>		15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO. <u>Mr. Dixie Chandler (Husband)</u> <u>Salisbury, Maryland</u>			
17. INFORMANT <u>Mr. Dixie Chandler (Husband)</u> <u>Salisbury, Maryland</u>									
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <u>Methyl Alcohol poisoning</u> <u>880.0</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. } DUE TO (b) _____ (c) _____ PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I: <u>Chronic Alcoholism</u>									
19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>									
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING CAUSE OF DEATH. <input type="checkbox"/> 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) <u>Ingested methyl alcohol</u>									
20c. TIME OF INJURY Month, Day, Year <u>Nov. 22, 1960</u> 20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input checked="" type="checkbox"/> 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <u>Home</u> 20f. (City or town) <u>Salisbury</u> (County) <u>Wicomico</u> (State) <u>MD</u>									
21. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from: Natural causes <input type="checkbox"/> Accident <input checked="" type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>									
22. ACTUAL SIGNATURE <u>Dr. Earl L. Royer</u> M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>									
EXAMINER'S NAME (Type) <u>Dr. Earl L. Royer</u> ADDRESS (Street, city, town, or county) <u>407 Camden Ave., Salisbury, Md.</u> DATE SIGNED <u>Nov. 25 1960</u>									
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u> 22b. DATE THEREOF <u>Nov. 28, 1960</u> 22c. NAME OF CEMETERY OR CREMATORY <u>Wicomico Memorial Park</u> 22d. LOCATION (City, town, or country) <u>Salisbury, Maryland</u>									
23. FUNERAL DIRECTOR <u>HOLLOWAY & COMPANY</u> ADDRESS <u>SALISBURY MARYLAND</u> 24a. REC'D BY REGISTRAR <u>DEC 1 '60</u> 24b. REGISTRAR'S SIGNATURE <u>Arthur L. Kline</u>									



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Board of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

CERTIFICATE OF DEATH
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND

13171

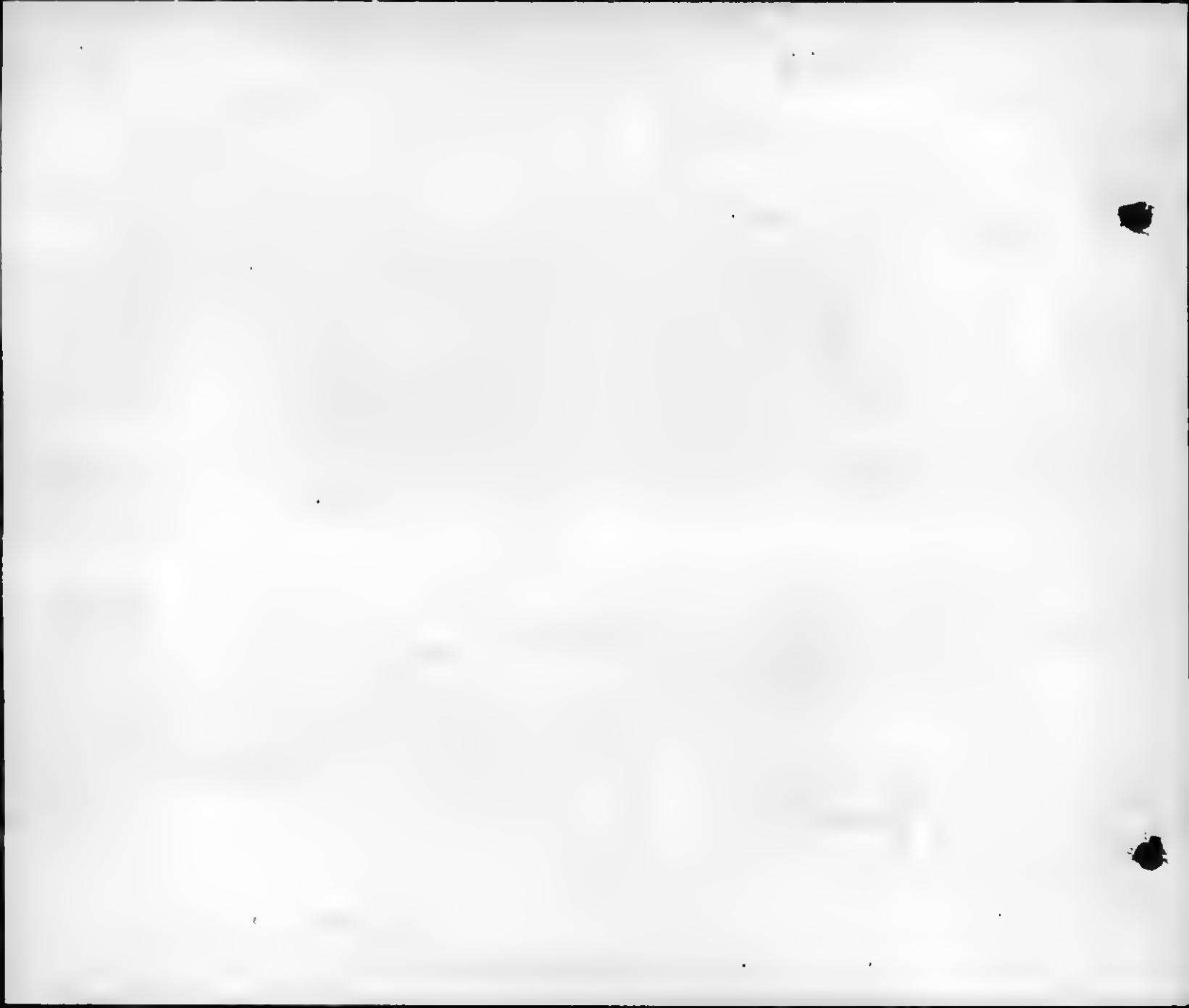
CERTIFICATE OF DEATH

13146

See: Birth Cert. et

1 PLACE OF DEATH a. COUNTY <u>Wicomico</u> MARYLAND		2 USUAL RESIDENCE (Where deceased lived. If institution Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Somerset</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Salisbury</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Westover</u> 19 X	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Peninsula General Hospital</u>		d. STREET ADDRESS <u>Box 254</u>	
3. NAME OF DECEASED (Type or print) First Middle Last <u>Collins</u>		4. DATE OF DEATH Month Day Year <u>November 3 - 1960</u>	
5 SEX <u>Female</u>	6 COLOR OR RACE <u>Negro</u>	7 MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>November 3, 1960</u>
9. AGE (In years last birthday) <u>5</u> yrs		IF UNDER 1 YEAR: IF UNDER 24 HRS: Months Days Hours Min.	
10a USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10b KIND OF BUSINESS OR INDUSTRY	11 BIRTHPLACE (State or foreign country) <u>Salisbury, Maryland</u>
12 CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>		13. FATHER'S NAME <u>Earl Sylvester Collins</u>	
14. MOTHER'S MAIDEN NAME <u>Bernice Lottie Ballard</u>		15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <input type="checkbox"/> (If yes, give war or dates of service)	
16. SOCIAL SECURITY NO.		17. INFORMANT Address	
18 CAUSE OF DEATH [Enter only one cause per line for (a), (b) and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Prematurity - 600 gm infant</u> 776X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the <u>underlying</u> cause lost. (b) DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			INTERVAL BETWEEN ONSET AND DEATH
20a ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c TIME OF INJURY Month Day Year Hour o. m. p. m. <u>19</u>		20d INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f (City or town) (County) (State)	
21 I certify that (I) (this hospital) attended the deceased from <u>11/3</u> 19 <u>60</u> to <u>11/3</u> 19 <u>60</u> that (I) (we) last saw the deceased alive on <u>11/3</u> 19 <u>60</u> and that death occurred at <u>7:00</u> M, from the causes and on the date stated above.			
22a SIGNATURE <u>William C. Morgan</u> M.D.		22b ADDRESS	
22c PHYSICIAN'S NAME (Type)		22d ADDRESS	
23a BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		23b DATE THEREOF <u>11/4/60</u>	
23c NAME OF CEMETERY OR CREMATORY <u>St James</u>		23d LOCATION (City, town or county) (State) <u>Westover, Maryland</u>	
24 FUNERAL DIRECTOR'S SIGNATURE <u>William H. Jones Jr.</u> ADDRESS <u>Princess Anne, Md</u>		25a REC'D BY REGISTRAR DATE <u>NOV 9 '60</u>	
25b REGISTRAR'S SIGNATURE <u>Arthur S. Thomas</u>			

218217/XVO



may be retained by the hospital or attending physician.
 THE FUNERAL DIRECTOR After this certificate has been signed by the attending physician and completely filled in, the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Board of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

1
 MARYLAND STATE DEPARTMENT OF HEALTH
 DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND

CERTIFICATE OF DEATH

13147

13172 See: Birth Cert. at

1. PLACE OF DEATH a. COUNTY <u>Wicomico</u> b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Salisbury</u> c. LENGTH OF STAY IN lb		2. USUAL RESIDENCE (Where deceased lived If institution Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Southern</u> c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Westover</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Peninsula General Hospital</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Middle Last <u>Collins</u>		4. DATE OF DEATH Month Day Year <u>November 3 - 1960</u>	
5. SEX <u>Female</u>	6. COLOR OR RACE <u>Negro</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>Nov. 3, 1960</u>
9. AGE (In years lost birthday) yrs. <u>7</u>	10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)	11. BIRTHPLACE (State or foreign country) <u>Salisbury, Maryland</u>	12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>
13. FATHER'S NAME <u>Earl Sylvester Collins</u>		14. MOTHER'S MAIDEN NAME <u>Bernice Lottie Ballard</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown)		16. SOCIAL SECURITY NO.	
17. INFORMANT		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c)] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Immaturity (Birth wt 580 gms)</u> DUE TO (b) <u>776</u> Conditions, if any which gave rise to immediate cause (a), stating the underlying cause last. (c) <u>aprox 9 hrs</u>			INTERVAL BETWEEN ONSET AND DEATH
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <u>19</u>	20d. INJURY OCCURRED While <input type="checkbox"/> at work Not while <input type="checkbox"/> at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg, etc.)	20f. (City or town) (County) (State)
21. I certify that (I) (this hospital) attended the deceased from <u>11/3</u> <u>1960</u> to <u>11/3</u> <u>1960</u> that (I) (we) last saw the deceased alive on <u>11/3</u> <u>1960</u> and that death occurred at <u>2:50</u> P.M. from the causes and on the date stated above.			
22a. SIGNATURE <u>Alfred C. Kolls</u> M.D.		22b. DATE SIGNED <u>11/3/60</u>	
22c. PHYSICIAN'S NAME (Type)		22d. ADDRESS <u>Medical Center - Salisbury, Md</u>	
23a. BURIAL, CREMATION, REMOVAL (Specify)	23b. DATE THEREOF <u>11/4/60</u>	23c. NAME OF CEMETERY OR CREMATORY <u>ST James</u>	23d. LOCATION (City, town, or county) (State) <u>Westover, Md</u>
24. FUNERAL DIRECTOR'S SIGNATURE <u>Willie H. Jones Jr.</u>		25a. REGISTERED BY REGISTRAR <u>Nov 5 1960</u>	
ADDRESS <u>Princess Anne, Md</u>		25b. REGISTRAR'S SIGNATURE <u>Charles L. Thomas</u>	

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filled with the State Board of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

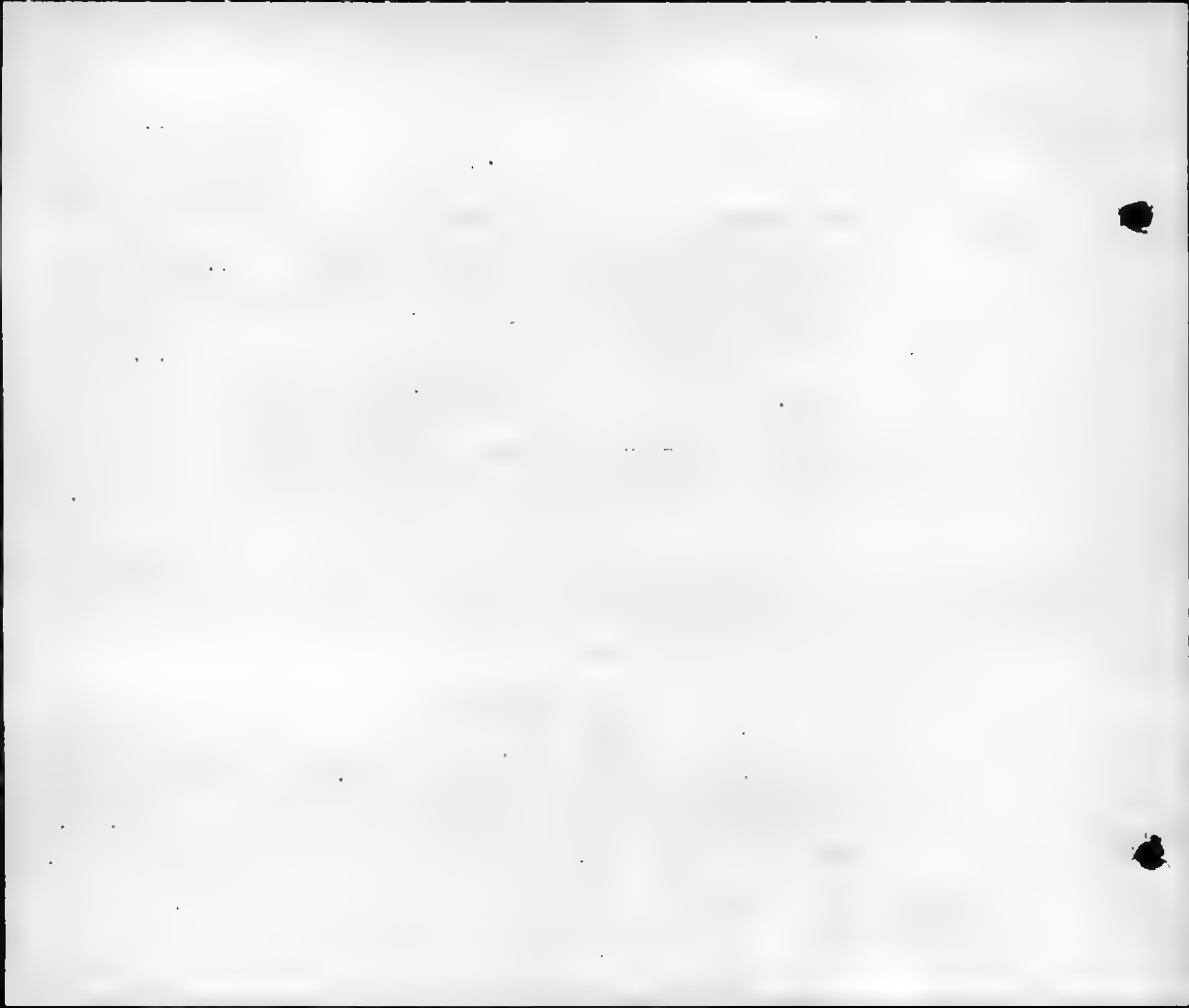
VR A15 (4)
15M 9/59

13173

13148

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND
CERTIFICATE OF DEATH

1. PLACE OF DEATH a. COUNTY Wicomico b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Salisbury c. LENGTH OF STAY IN lb 7 days d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Pine Bluff State Hospital		2. USUAL RESIDENCE (Where deceased lived. If institution, Residence before admission) a. STATE Maryland b. COUNTY Queen Anne's c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Centerville d. STREET ADDRESS e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Middle Last JAMES ALISON DADDS		4. DATE OF DEATH Month Day Year Nov. 30 19 60	
5. SEX M	6. COLOR OR RACE W	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH Sept. 11, 1888
9. AGE (In years lost birthday) 72 yrs		10. IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Huckster		10b. KIND OF BUSINESS OR INDUSTRY Farming	
11. BIRTHPLACE (State or foreign country) Maryland		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME William J. Dadds		14. MOTHER'S MAIDEN NAME Elizabeth Izzie Allen	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No		16. SOCIAL SECURITY NO. 212-16-72284	
17. INFORMANT Records of Pine Bluff Hospital		Address	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Pulmonary tuberculosis X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) DUE TO (c)		INTERVAL BETWEEN ONSET AND DEATH 5 mos.	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) Arteriosclerotic cardiovascular disease		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a m p m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from Nov. 23 1960 to Nov. 30 1960 , that (I) (we) last saw the deceased alive on Nov. 30 1960 , and that death occurred at 8:45 PM from the causes and on the date stated above.			
22a. SIGNATURE Edward P. Ritchings M.D.		22b. DATE SIGNED Nov. 30, 1960	
22c. PHYSICIAN'S NAME (Type) Edward P. Ritchings, M.D.		22d. ADDRESS Pine Bluff State Hosp., Salisbury, Md.	
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE THEREOF Dec 3-1960	
23c. NAME OF CEMETERY OR CREMATORY Chestnutfield		23d. LOCATION (City, town, or county) (State) Centerville Maryland	
24. FUNERAL DIRECTOR'S SIGNATURE James W. Butler of Butler Bros., Centerville, Md.		25a. REC'D BY REGISTRAR DEC 6 '60	
25b. REGISTRAR'S SIGNATURE Charles S. House			

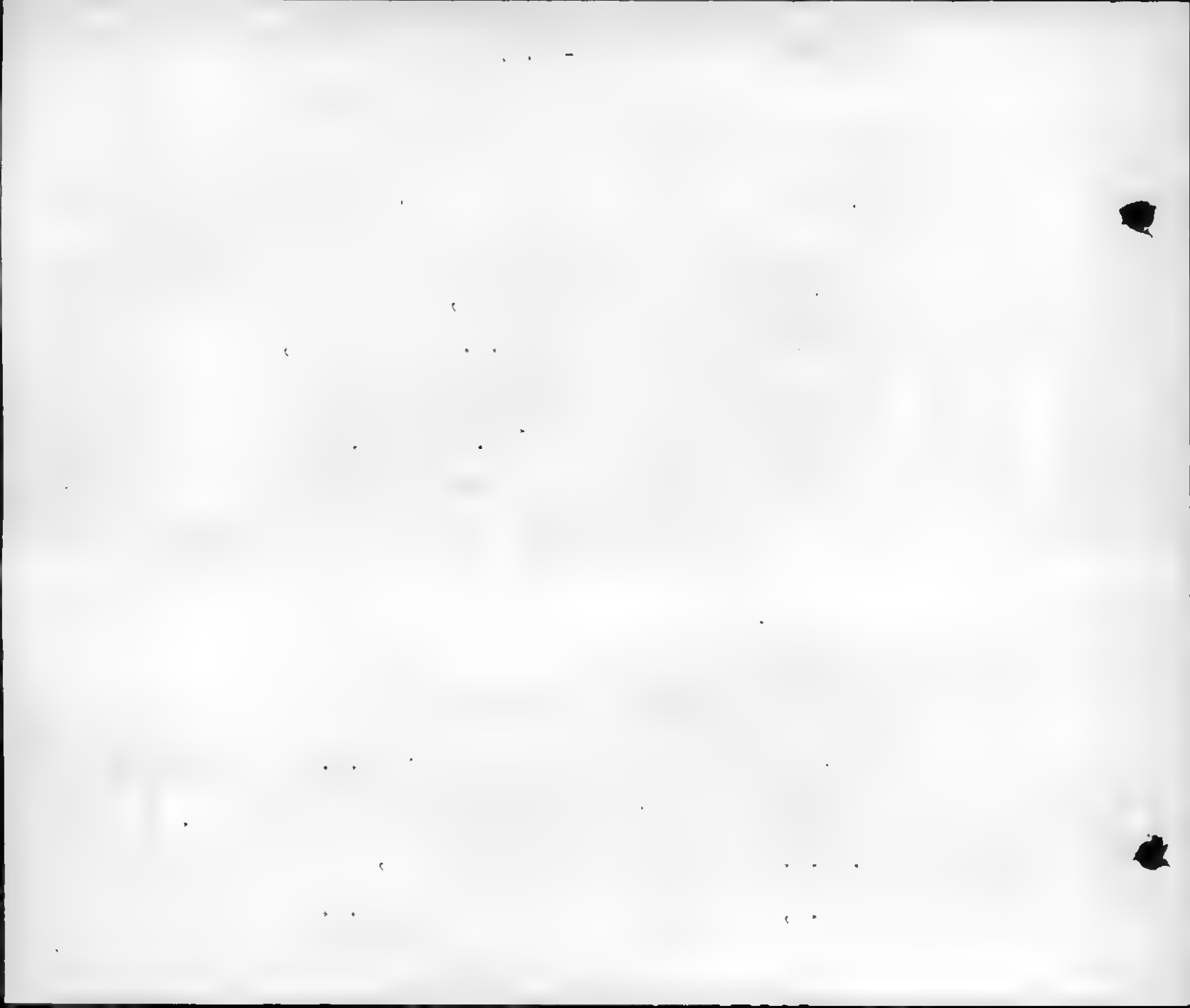


MARYLAND STATE DEPARTMENT OF HEALTH
 DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND
CERTIFICATE OF DEATH

13217

13149

1. PLACE OF DEATH a. COUNTY Wicomico MARYLAND		2. USUAL RESIDENCE (Where deceased lived If institution Residence before admision) a. STATE Maryland b. COUNTY Wicomico	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Delmar		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Delmar	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION 506 Chestnut St		e. STREET ADDRESS 506 Chestnut St	
3. NAME OF DECEASED (Type or print) First RAYMOND Middle HOOKS Last DAVIS		4. DATE OF DEATH Month NOV Day 7 Year 1960	
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH May 23, 1892
9. AGE (In years last birthday) 68 yrs		10. IF UNDER 1 YEAR Months 6 Days 13 Hours 6 Min.	11. IF UNDER 24 HRS. Hours 6 Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Night Watchman - Factory - Employee		10b. KIND OF BUSINESS OR INDUSTRY B.D.# Pittsville, Md	
11. BIRTHPLACE (State or foreign country) U S A		12. CITIZEN OF WHAT COUNTRY? U S A	
13. FATHER'S NAME John Davis		14. MOTHER'S MAIDEN NAME Henrietta Campbell	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No		16. SOCIAL SECURITY NO. 17. INFORMANT Mrs. Martha Ellen Davis (Wife) 506 Chestnut St. Delmar, Maryland	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c)] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Coronary Thrombosis DUE TO (b) Coronary arteriosclerosis DUE TO (c) Generalized arteriosclerosis Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) Generalized arteriosclerosis			INTERVAL BETWEEN ONSET AND DEATH 1 hour
20a. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) N/A		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18) N/A	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. N/A 19	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) N/A	20f. (City or town) (County) (State) N/A
21. I certify that (I) (this hospital) attended the deceased from 1958 that (I) (we) last saw the deceased alive on December 27 , and that death occurred at 11:58 P.M. from the causes and on the date stated above.			
22a. SIGNATURE L.V. Sohler		22b. DATE SIGNED Nov. 7 / 1960	
22c. PHYSICIAN'S NAME (Type) Dr. L.V. Sohler		22d. ADDRESS Delmar, Maryland	
23a. BURIAL, CREMATION, REMOVAL, (Specify) Burial	23b. DATE THEREOF Nov. 3, 1960	23c. NAME OF CEMETERY OR CREMATORY Fairview Cemetery	23d. LOCATION (City, town, or county) (State) R.D.# Pittsville, Maryland
24. FUNERAL DIRECTOR'S SIGNATURE PORTER & COMPANY		25a. REC'D BY REGISTRAR DATE NOV 9 '60	
25b. REGISTRAR'S SIGNATURE C. L. & K. K.			



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be returned by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Board of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
15M 9/59

1
13174
MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND
CERTIFICATE OF DEATH

13150

1. PLACE OF DEATH a. COUNTY Wicomico MARYLAND		2. USUAL RESIDENCE (Where deceased lived (If institution Residence before admission) a. STATE Maryland b. COUNTY Worcester	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Salisbury		c. LENGTH OF STAY IN 1b 965 days	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION DEER'S HEAD STATE HOSPITAL		d. STREET ADDRESS --	
3. NAME OF DECEASED (Type or print) First Mary Middle Priscilla Last Devereaux		4. DATE OF DEATH Month 11 Day 8 Year 1960	
5. SEX F	6. COLOR OR RACE W	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 4-5-81
9. AGE (In years last birthday) 79 yrs		10. IF UNDER 1 YEAR Months Days Hours Min	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife		10b. KIND OF BUSINESS OR INDUSTRY own home	
11. BIRTHPLACE (State or foreign country) Snow Hill, Md		12. CITIZEN OF WHAT COUNTRY?	
13. FATHER'S NAME Joseph J. Devereaux		14. MOTHER'S MAIDEN NAME Kennetta Evans	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (If yes, give war or dates of service) no		16. SOCIAL SECURITY NO none	
17. INFORMANT Joseph J. Devereaux, Snow Hill, Md		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: 434 IMMEDIATE CAUSE (a) Congestive heart disease DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last (b) DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) Diabetes mellitus; arteriosclerosis, general.		INTERVAL BETWEEN ONSET AND DEATH 10 days	
19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from 3-19, 1958 , to 11-8, 1960 , that (I) (we) last saw the deceased alive on 11-8, 1960 , and that death occurred at 10:45 p.m. M, from the causes and on the date stated above.			
22a. SIGNATURE [Signature]		22b. DATE SIGNED 11-9-60	
22c. PHYSICIAN'S NAME (Type) L. V. Maldve, M.D.		22d. ADDRESS Deer's Head State Hospital Salisbury, Maryland	
23a. BURIAL CREMATION REMOVAL (Specify) Burial		23b. DATE THEREOF Nov 13/60	
23c. NAME OF CEMETERY OR CREMATORY Whateoat Cemetery		23d. LOCATION (City, town or county) (State) Snow Hill Md	
24. FUNERAL DIRECTOR'S SIGNATURE [Signature]		25a. REC'D BY REGISTRAR NOV 14 '60	
ADDRESS Snow Hill, Md		25b. REGISTRAR'S SIGNATURE Arthur L. Evans	



MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND

13151

13175

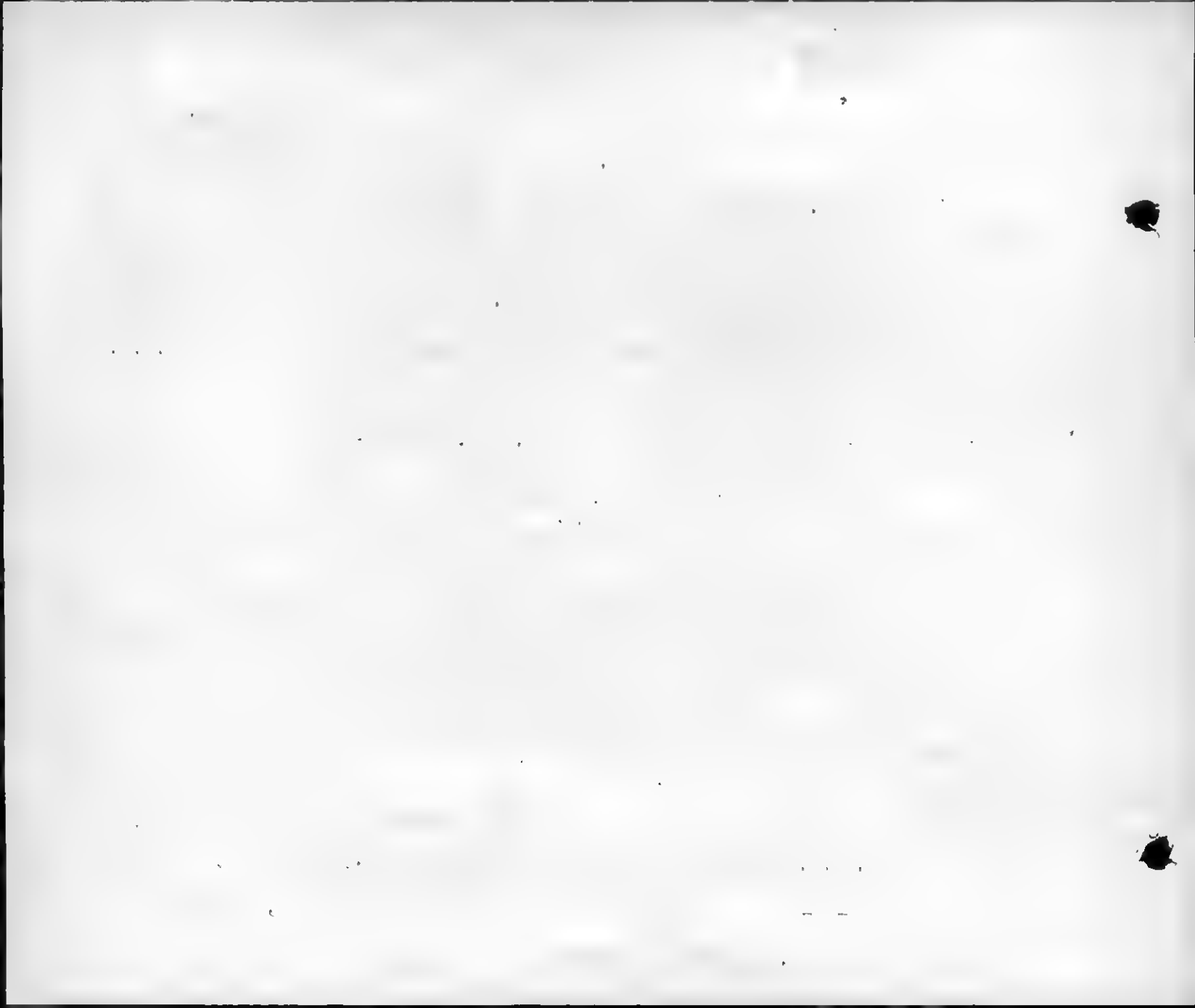
Item 2 Film 62-76-12-2-60 et

CERTIFICATE OF DEATH

1. PLACE OF DEATH a. COUNTY Wicomico b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Salisbury		MARYLAND c. LENGTH OF STAY IN 1b 1 1/2 Yrs.		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Wicomico c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Salisbury		d. STREET ADDRESS 307 Newton St.		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION John B. Parsons Home		3. NAME OF DECEASED (Type or print) First SINA Middle TAYLOR Last DICKERSON		4. DATE OF DEATH Month 11 Day 25 Year 1960		5. SEX Female		6. COLOR OR RACE White	
7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH May 2, 1863		9. AGE (In years last birthday) 97 yrs		IF UNDER 1 YEAR Months 11 Days 25 Hours 19 Min. 60		10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) House Wife	
10b. KIND OF BUSINESS OR INDUSTRY Own Home		11. BIRTHPLACE (State or foreign country) Maryland		12. CITIZEN OF WHAT COUNTRY? U.S.A.		13. FATHER'S NAME John Thomas Taylor		14. MOTHER'S MAIDEN NAME Sarah White	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No		16. SOCIAL SECURITY NO. None		17. INFORMANT John B. Parsons Home, Same		Address			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) 4422 Cardiovascular renal disease Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) DUE TO (c) DUE TO									
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) INTERVAL BETWEEN ONSET AND DEATH									
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)					20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part or Part II of item 18.)				
20c. TIME OF INJURY Month, Day, Year Hour o. m. 19 p. m.			20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)			20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from 1957 to 11-25-1960 , that (I) (we) last saw the deceased alive on 11-29-1960 , and that death occurred at M , from the causes and on the date stated above									
22a. SIGNATURE Philip A. Insley					22b. DATE SIGNED 11-26-1960				
22c. PHYSICIAN'S NAME (Type) Dr. Philip A. Insley					22d. ADDRESS Salisbury, Maryland				
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE THEREOF 11-27-1960		23c. NAME OF CEMETERY OR CREMATORY Parsons Cemetery		23d. LOCATION (City, town, or county) (State) Salisbury, Maryland			
24. FUNERAL DIRECTOR'S SIGNATURE Hill & Johnson Co. Salisbury, Maryland					25a. REC'D BY REGISTRAR DATE NOV 29 '60		25b. REGISTRAR'S SIGNATURE Arthur L. Thomas		







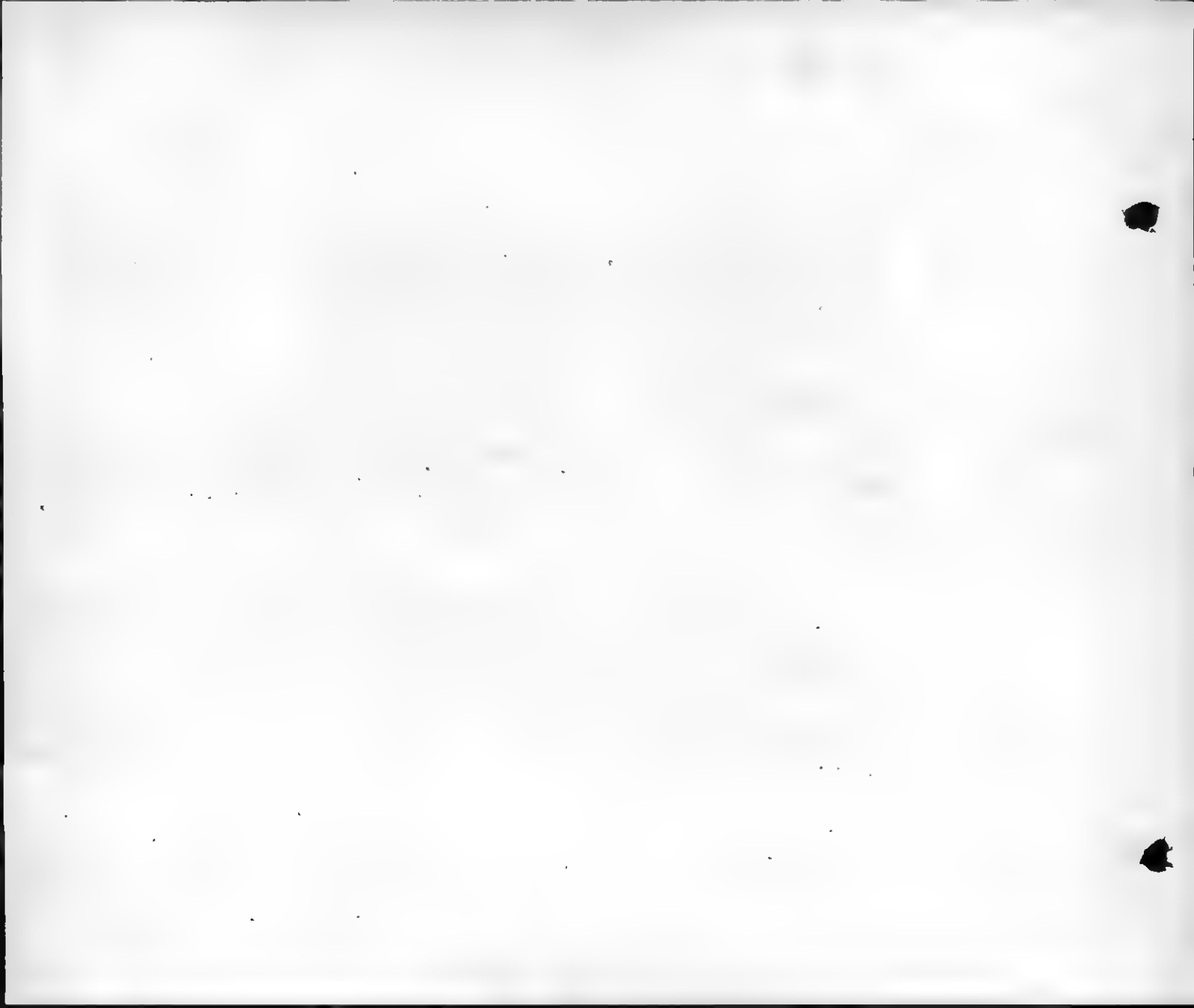
13218. CERTIFICATE OF DEATH

Reg. Dist. No. 13153

1. PLACE OF DEATH a. COUNTY <u>Wicomico</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Wicomico</u>	
b. CITY OR TOWN (If outside of corporate limits, write RURAL and give nearest town) <u>Fruitland</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Fruitland</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Meadow Brook Road</u>		e. IS RESIDENCE ON A FARM? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <u>Pierce</u> Middle <u>A.</u> Last <u>Doane</u>		4. DATE OF DEATH Month <u>November</u> Day <u>20</u> Year <u>1960</u>	
5. SEX <u>M.</u>	6. COLOR OR RACE <u>C.</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>October 13, 1959</u>
9. AGE (In years last birthday) yrs <u>13</u>		10. IF UNDER 1 YEAR Months <u>13</u> Days <u></u> Hours <u></u> Min <u></u>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>None</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Maryland</u>	
11. BIRTHPLACE (State or foreign country) <u>U.S.A.</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>William Doane</u>		14. MOTHER'S MAIDEN NAME <u>Carolyn Horsey</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>no</u>		16. SOCIAL SECURITY NO. <u>no</u>	
17. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Acute Broncho Pneumonia</u> DUE TO (b) <u>Viral Bronchitis</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (c) <u></u>		INTERVAL BETWEEN ONSET AND DEATH <u>2 days</u>	
PART II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u></u>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18) <u></u>	
20c. TIME OF INJURY Month, Day, Year Hour <u>19</u> o. m. <u></u> p. m. <u></u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office, etc.) <u></u>		20f. (City or town) (County) (State) <u></u>	
21. I certify that I attended the deceased from <u>Nov. 19, 1960</u> to <u>Nov. 20, 1960</u> that I last saw the deceased alive on <u>Nov. 19, 1960</u> and that death occurred at <u>7:00</u> A.M. from the causes and on the date stated above.			
ACTUAL SIGNATURE <u>G. Herbert Sembley</u> M.D.		ADDRESS (Street, city or town, state) <u>400 E. Church St. Salisbury Md</u>	
PHYSICIAN'S NAME (Type) <u>G. Herbert Sembley</u>		DATE SIGNED <u>11/20/60</u>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>burial</u>		22b. DATE THEREOF <u>11/23/1960</u>	
22c. NAME OF CEMETERY OR CREMATORY <u>green acres</u>		22d. LOCATION (City, town, or county) (State) <u>Salisbury Md</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>Clinton H. Stewart</u>		24a. REC'D BY REGISTRAR DATE <u>NOV 29 '60</u>	
ADDRESS <u>Salisbury Md</u>		24b. REGISTRAR'S SIGNATURE <u>Arthur S. Thoms</u>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 48 hours after death.



FOR STATE
HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If an autopsy is necessary, please execute the certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM-3. Page 5 may be retained for your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS. A15ME
SM 7/59

MEDICAL CERTIFICATION

<div> <div> <div>1</div> <div>FOR STATE HEALTH DEPT.</div> </div> <div> <div>13220</div> <div>MEDICAL EXAMINER'S CERTIFICATE OF DEATH</div> <div>13154</div> </div> </div> <div> <div> <div>1</div> <div>TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If an autopsy is necessary, please execute the certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM-3. Page 5 may be retained for your files.</div> </div> <div> <div>TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.</div> </div> </div> <div>VS. A15ME SM 7/59</div>											
<div>1. PLACE OF DEATH</div> <div>a. COUNTY <u>Wicomico</u></div> <div>b. CITY OR TOWN (if out of corporate limits, write RURAL and give nearest town) <u>(Rural) Fruitland</u></div> <div>c. LENGTH OF STAY IN 1b <u>(Railroad Crossing)</u></div> <div>d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <u>Route 413 South of Fruitland</u></div>						<div>2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission)</div> <div>a. STATE <u>Maryland</u> b. COUNTY <u>Wicomico</u></div> <div>c. CITY OR TOWN (if out of corporate limits, write RURAL and give nearest town) <u>Salisbury</u></div> <div>d. STREET ADDRESS <u>R.D.# 1 (Pondor Bridge Rd)</u></div> <div>e. IS RESIDENCE ON A FARM? <input type="checkbox"/> YES <input type="checkbox"/> NO</div>					
<div>3. NAME OF DECEASED (Type or print) <u>RAYE</u></div> <div>4. DATE OF DEATH <u>NOV. 10 19 60</u></div>						<div>5. SEX <u>Female</u></div> <div>6. COLOR OR RACE <u>White</u></div> <div>7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/></div> <div>8. DATE OF BIRTH <u>Jan. 25, 1938</u></div> <div>9. AGE (In years IF UNDER 1 YEAR IF UNDER 24 HRS last birthday) <u>22 yrs. 9 Months 15 Days</u></div>					
<div>10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Employee-Shirt Factory "Operator"</u></div> <div>10b. KIND OF BUSINESS OR INDUSTRY <u>Salisbury, Maryland</u></div> <div>11. BIRTHPLACE (State or foreign country) <u>U S A</u></div> <div>12. CITIZEN OF WHAT COUNTRY? <u>U S A</u></div>						<div>13. FATHER'S NAME <u>No Record</u></div> <div>14. MOTHER'S MAIDEN NAME <u>Gladys Wilkerson</u></div>					
<div>15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>No</u></div> <div>16. SOCIAL SECURITY NO. <u>10</u></div> <div>17. INFORMANT <u>Mr. Elwood St (Grandfather) R.D.# 1 (Pondor Bridge Rd) Salisbury, Maryland</u></div> <div>18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c))</div>						<div>18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c))</div> <div>PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Compound Fracture of Skull</u></div> <div>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Swollen</u></div> <div>(c) <u>Swollen</u></div> <div>PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>Swollen</u></div>					
<div>19. WAS AUTOPSY PERFORMED? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO</div>						<div>20a. EXTERNAL CAUSE WAS PRIMARY <input checked="" type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.</div> <div>20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) <u>Passenger Auto Struck by Train</u></div>					
<div>20c. TIME OF INJURY Month, Day, Year <u>11/ 10, 60</u></div> <div>20d. INJURY OCCURRED While <input checked="" type="checkbox"/> Not While <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/></div> <div>20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <u>Railroad Crossing - Fruitland (Wico.) Md.</u></div> <div>20f. (City or town) (County) (State) <u>Salisbury, Maryland</u></div>						<div>21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from: Natural causes <input type="checkbox"/> Accident <input checked="" type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/></div>					
<div>ACTUAL SIGNATURE <u>Dr. Earl L. Royer</u></div> <div>EXAMINER'S NAME (Type) <u>407 Camden Ave. Salisbury, Md.</u></div>						<div>CHIEF MEDICAL EXAMINER <input type="checkbox"/></div> <div>ASSISTANT MEDICAL EXAMINER <input type="checkbox"/></div> <div>DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/></div> <div>DATE SIGNED <u>Nov. 17 /1960</u></div>					
<div>22a. BURIAL, CREMATION, REMOVAL (Specify) <u>burial</u></div> <div>22b. DATE THEREOF <u>Nov. 12, 1960</u></div> <div>22c. NAME OF CEMETERY OR CREMATORY <u>Shed Point Cemetery-</u></div> <div>22d. LOCATION (City, town, or country) (State) <u>R.D. Salisbury, Maryland</u></div>						<div>23. FUNERAL DIRECTOR <u>LO Y & COMPANY</u></div> <div>ADDRESS <u>SALISBURY MARYLAND</u></div> <div>24a. REC'D BY REGISTRAR <u>NOV 16 '60</u></div> <div>24b. REGISTRAR'S SIGNATURE <u>Arthur L. Kinney</u></div>					



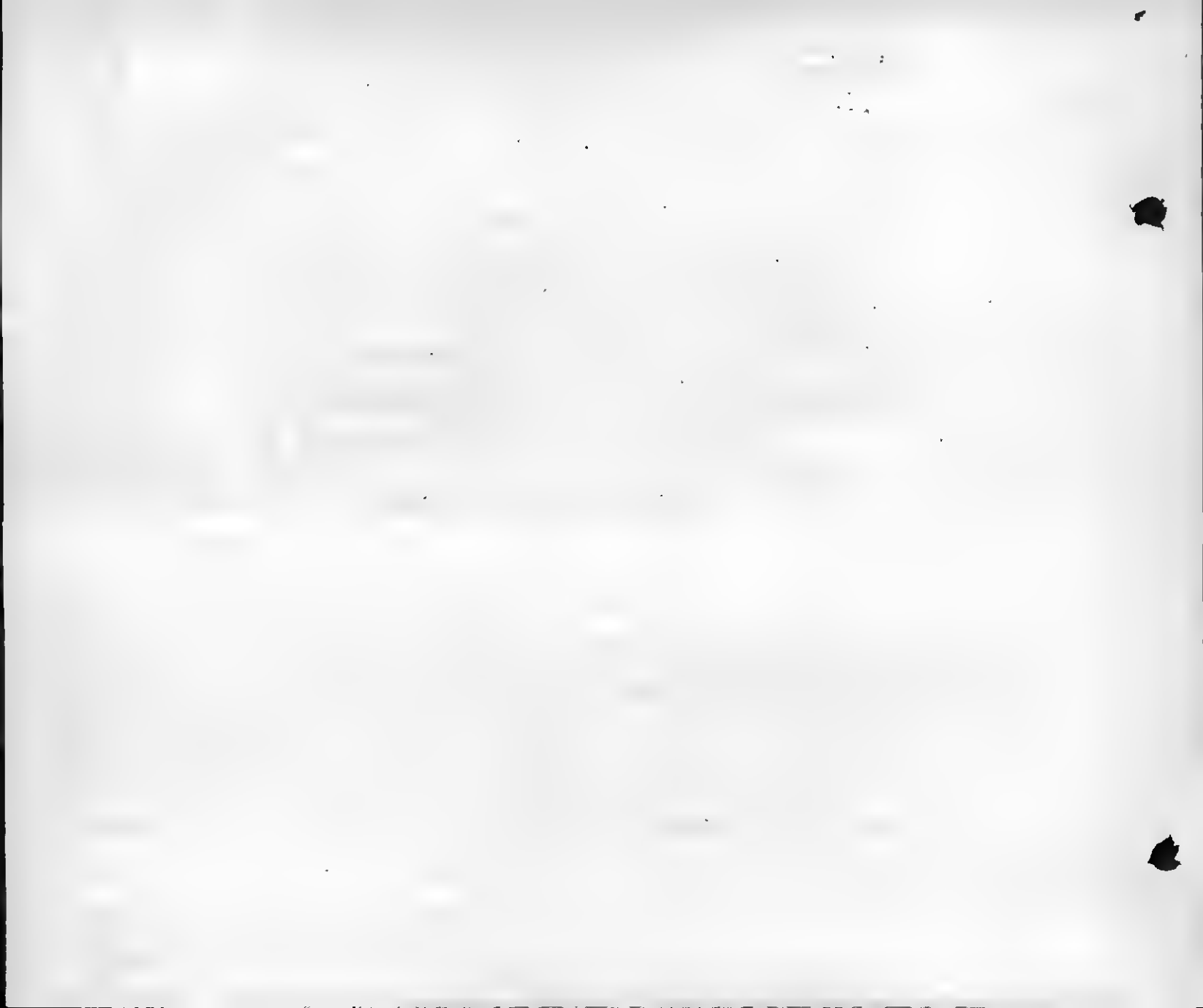
MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND
CERTIFICATE OF DEATH

13177

13155

1. PLACE OF DEATH a. COUNTY <u>Wicomico</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived If institution Residence before admission) a. STATE <u>MD</u> b. COUNTY <u>Worcester</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>SALISBURY</u>				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Snow Hill Rural #1</u>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>PENINSULA GENERAL HOSPITAL</u>				d. STREET ADDRESS <u>X</u>			
3. NAME OF DECEASED (Type or print) <u>Baby</u> First Middle Last				4. DATE OF DEATH <u>NOVEMBER 18 1960</u> Month Day Year			
5. SEX <u>FEMALE</u>		6. COLOR OR RACE <u>Colored</u>		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>NOVEMBER 17, 1960</u>	
9. AGE (In years last birthday) <u>5</u> yrs.		F UNDER 1 YEAR <u>5</u> Months <u>47</u> Days		IF UNDER 24 HRS. <u>47</u> Hours <u>47</u> Min.			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>None</u>				10b. KIND OF BUSINESS OR INDUSTRY <u>Salisbury, MD</u>		11. BIRTHPLACE (State or foreign country) <u>Salisbury, MD</u>	
12. CITIZEN OF WHAT COUNTRY? <u>None</u>				13. FATHER'S NAME <u>James Pope</u>			
14. MOTHER'S MAIDEN NAME <u>Margaret Dorsey</u>				15. WAS DECEASED EVER IN U. S. ARMED FORCES? <u>No</u> (If yes, give war or dates of service)			
16. SOCIAL SECURITY NO. <u>None</u>				17. INFORMANT <u>Mrs. Verilla Wecott, Nassawadox, Va</u> Address <u>Box 215</u>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Respiratory Failure</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Cardiac failure</u> (c) <u>Fatal Arteriosclerosis</u> PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>Atherosclerosis</u>							
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18)			
20c. TIME OF INJURY Month. Day. Year Hour o. m. p. m. <u>19</u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from <u>11/17</u> 19 <u>60</u> to <u>11/18</u> 19 <u>60</u> , that (I) (we) last saw the deceased alive on <u>11/18</u> 19 <u>60</u> , and that death occurred at <u>2:40</u> M. from the causes and on the date stated above.							
22a. SIGNATURE <u>William C. Morgan</u>				22b. DATE SIGNED <u>11/19/60</u>		22c. PHYSICIAN'S NAME (Type) <u>William C. Morgan</u>	
22d. ADDRESS <u>Medical Center, Salisbury, MD</u>				22e. REC'D BY REG. STRAR <u>Nov 23 '60</u>			
23a. MARRIAGE, CREMATION, REMOVAL (Specify) <u>Funeral Nov 21/60</u>				23b. DATE THEREOF <u>Nov 21/60</u>		23c. NAME OF CEMETERY OR CREMATORY <u>Salisbury Simple Landings</u>	
23d. LOCATION (City, town, or county) <u>Snow Hill, MD</u>				23e. (State) <u>MD</u>			
24. FUNERAL DIRECTOR'S SIGNATURE <u>Maye B. Dumas</u>				25a. REGISTRAR'S SIGNATURE <u>John S. Kline</u>			

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Board of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.



TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please enclose 1 - certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM-3. Page 5 may be retained for your records.
TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the registrar prior to burial, cremation, or removal.

VS. A15ME(S)
SM 9/55

MARYLAND STATE DEPARTMENT OF HEALTH--BALTIMORE, 18

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

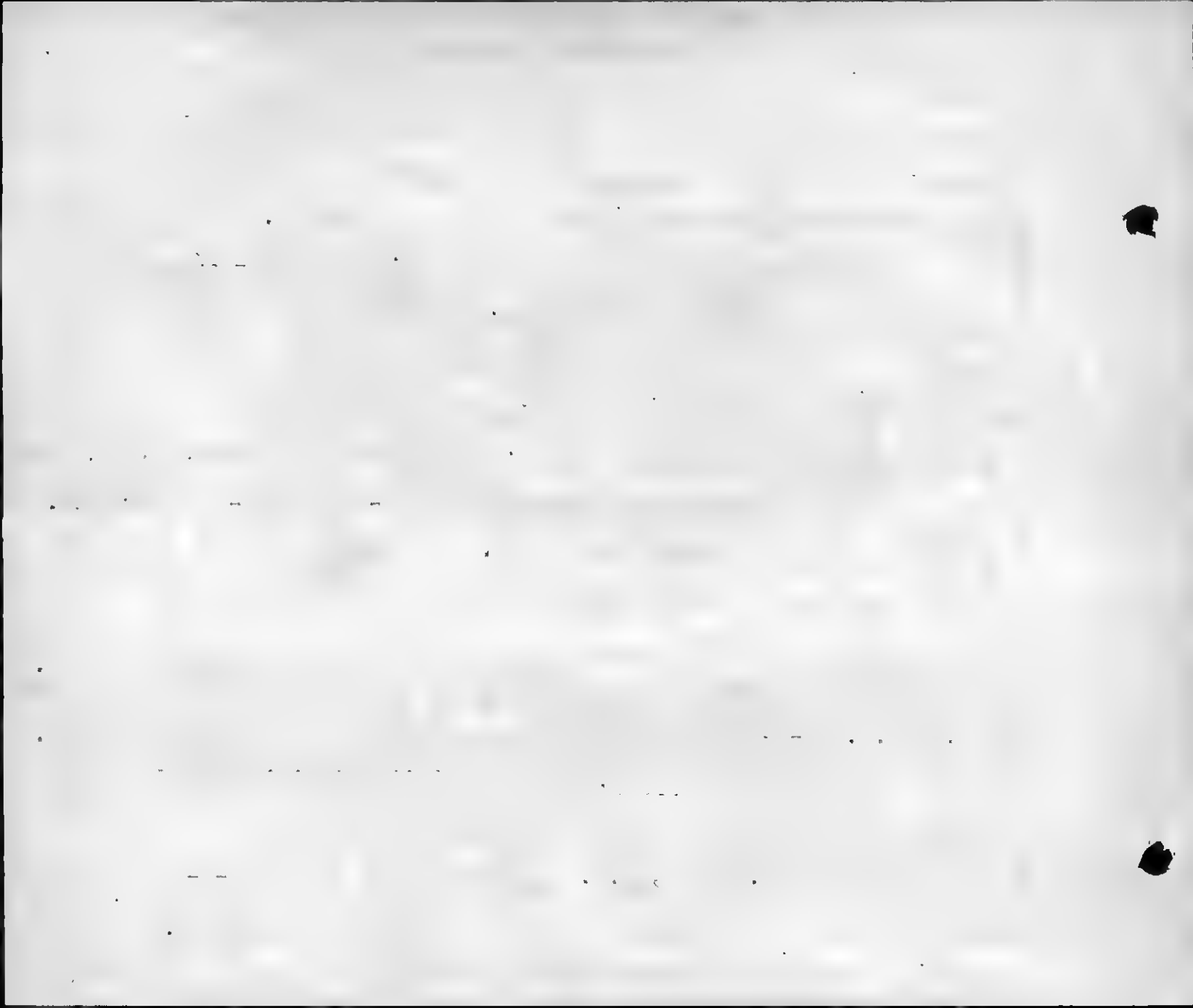
13178

Item 6 & 9, Form 6-2, 4 11/10/60, cac.

Reg. Dist. No.

13156

1. PLACE OF DEATH a. COUNTY Wicomico MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If Institution: Residence before admission) a. STATE Maryland b. COUNTY Wicomico	
b. CITY OR TOWN (If outside of corporate limits, write RURAL and give nearest town) Salisbury		c. LENGTH OF STAY IN 1b	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Peninsula General Hospital		d. STREET ADDRESS 413 Welles St.	
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First Middle Last Pierre Fleischauer Jr.		4. DATE OF DEATH Month Day Year 11-5-60	
5. SEX M	6. COLOR OR RACE W	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input checked="" type="checkbox"/>	8. DATE OF BIRTH 1925 Nov. 23, 1925
9. AGE (In years last birthday) 35 yrs.		10. IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Printer		10b. KIND OF BUSINESS OR INDUSTRY Printer	
11. BIRTHPLACE (State or foreign country) Maryland		12. CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME Pierre Fleischauer Sr.		14. MOTHER'S MAIDEN NAME Florence Powell	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) World War # 2		16. SOCIAL SECURITY NO.	
17. INFORMANT Mrs. Thelma Dickman Salisbury, Md.		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Compound fracture of skull-occipital- DUE TO Fractured cervical spine Sudden. Conditions, if any, which gave rise to immediate cause (b) Crushed left chest. DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) threw him out. & threw him out of control, hit pole and the			
20a. EXTERNAL CAUSE WAS PRIMARY <input checked="" type="checkbox"/> OR CONTRIBUTING CAUSE OF DEATH <input type="checkbox"/>		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) Driving car that ran out of control, hit pole and the	
20c. TIME OF INJURY Month, Day, Year 2:35 A.M. 11-5-60		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input checked="" type="checkbox"/> Highway	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) Salisbury Wicomico Md.		20f. (City or town) (County) (State)	
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and find that death resulted from: Natural causes <input type="checkbox"/> Accident <input checked="" type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined cause <input type="checkbox"/> .			
ACTUAL SIGNATURE Earl L. Royer		M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/>	
EXAMINER'S NAME (Type) Earl L. Royer, M.D.		ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>	
		DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>	
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 11/6/60	
22c. NAME OF CEMETERY OR CREMATORY Dale		22d. LOCATION (City, town, or county) (State) Whaleyville, Md.	
23. FUNERAL DIRECTOR'S SIGNATURE Peter Whaley		24a. REC'D BY REGISTRAR NOV/6 '60	
		24b. REGISTRAR'S SIGNATURE Arthur S. Evans	



MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND
CERTIFICATE OF DEATH

13157

13179

1. PLACE OF DEATH a. COUNTY <u>Wicomico</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution, residence before admission) a. STATE <u>MARYLAND</u> b. COUNTY <u>WORCESTER</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Salisbury</u>				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>POCOMOKE CITY</u>			
c. LENGTH OF STAY IN 1b <u>7 DAYS</u>				d. STREET ADDRESS <u>203 SIXTH STREET</u>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Peninsula General Hospital</u>				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First Middle Last <u>WILLIAM M. Fleming</u>				4. DATE OF DEATH Month Day Year <u>November 14 1960</u>			
5. SEX <u>Male</u>		6. COLOR OR RACE <u>White</u>		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>NOV. 3, 1875</u>	
9. AGE (In years last birthday) <u>85</u> yrs		IF UNDER 1 YEAR Months Days		IF UNDER 24 HRS. Hours Min			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>LUMBER MFG.</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>LUMBER</u>		11. BIRTHPLACE (State or foreign country) <u>PENNSYLVANIA</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>WILLIAM E. FLEMING</u>				14. MOTHER'S MAIDEN NAME <u>ELIZABETH SPROUL</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>NO.</u> (If yes, give war or dates of service)				16. SOCIAL SECURITY NO. <u>170-10-6339</u>		17. INFORMANT Address <u>MRS MARY M. FLEMING, 203 SIXTH STREET, POCOMOKE CITY, MD.</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Carcinoma of lung -</u> DUE TO (b) _____ Conditions, if any, which gave rise to immediate cause (c), stating the underlying cause lost. (c) _____ DUE TO (b) _____ DUE TO (c) _____ PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) _____ 19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18)			
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <u>19</u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from <u>11-9</u> 19 <u>60</u> to <u>11-14</u> 19 <u>60</u> , that (I) (we) last saw the deceased alive on <u>11-14</u> 19 <u>60</u> , and that death occurred at <u>8 PM</u> , from the causes and on the date stated above.							
22a. SIGNATURE <u>William M. Fleming</u> M.D.				ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22b. DATE SIGNED <u>11-15-60</u>	
22c. PHYSICIAN'S NAME (Type) <u>WILBUR R. ELLIS</u>				22d. ADDRESS <u>SALISBURY, MARYLAND</u>			
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>BURIAL</u>		23b. DATE THEREOF <u>11-17-60</u>		23c. NAME OF CEMETERY <u>ST. MARY EPISCOPAL</u>		23d. LOCATION (City, town, or county) (State) <u>POCOMOKE CITY, MARYLAND</u>	
24. FUNERAL DIRECTOR'S SIGNATURE <u>Robert H. Watern</u> ADDRESS <u>POCOMOKE CITY, MD.</u>				25a. REC'D BY REGISTRAR <u>NOV 21 1960</u> DATE		25b. REGISTRAR'S SIGNATURE <u>Curran S. Jones</u>	

TO HOSPITAL: The low requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Board of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.



TO HOSPITAL: The low requires that the death certificate be executed within 24 hours after death. Page 4
TO ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 24 hours after death. Page 4
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Board of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

13221

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND
CERTIFICATE OF DEATH

13158

1. PLACE OF DEATH a. COUNTY Wicomico MARYLAND		2. USUAL RESIDENCE (Where deceased lived If institution Residence before admission) a. STATE Maryland b. COUNTY Wicomico	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Pittsville		c. LENGTH OF STAY IN 1b X CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Pittsville	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION R.D.#		d. STREET ADDRESS 1 R.D.#	
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First CARRIE Middle GARTNER Last GARTNER		4. DATE OF DEATH Month NOVEMBER Day 5 Year 1960	
5. SEX Female	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH June 27, 1870
9. AGE (In years last birthday) 90 yrs	IF UNDER 1 YEAR Months 4 Days 8	IF UNDER 24 HRS Hours Min. 	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) House work at home		10b. KIND OF BUSINESS OR INDUSTRY None	11. BIRTHPLACE (State or foreign country) Brooklyn, New York
12. CITIZEN OF WHAT COUNTRY? U S A			
13. FATHER'S NAME John Erig		14. MOTHER'S MAIDEN NAME Johanna Merissenhalter	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No		16. SOCIAL SECURITY NO 	
17. INFORMANT Mr. Charles L. Gartner (Son) Address Pittsville, Maryland			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c)] PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) Chr. myocarditis 422.0 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) DUE TO (c) 			INTERVAL BETWEEN ONSET AND DEATH 3.5 years
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) Diabetes mellitus			19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) N/A		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18) N/A	
20c. TIME OF INJURY Month, Day, Year Hour 0 p. m. N/A 19 60	20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) N/A	20f. (City or town) N/A (County) (State)
21. I certify that (I) (this hospital) attended the deceased from Aug 17, 1955 to 11-5 , 19 60 , that (I) (we) last saw the deceased alive on Nov 1 , 19 60 , and that death occurred at 3:30 A.M. from the causes and on the date stated above			
22a. SIGNATURE Frank Lewis		22b. DATE SIGNED Nov. 7 / 1960	
22c. PHYSICIAN'S NAME (Type) Dr. Frank R. Lewis		22d. ADDRESS Willards, Maryland	
23a. BURIAL CREMATION REMOVAL (Specify) Burial	23b. DATE THEREOF Nov. 9 / 1960	23c. NAME OF CEMETERY OR CREMATORY Lutheran Cemetery-Middle Village (nurs) N.Y.	23d. LOCATION (City, town, or county) (State)
24. FUNERAL DIRECTOR'S SIGNATURE HOILEY & COMPANY ADDRESS SALISBURY MARYLAND		25a. REC'D BY REGISTRAR DATE NOV 9 '60	25b. REGISTRAR'S SIGNATURE Arthur S. Thomas



MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND
CERTIFICATE OF DEATH

13180

13159

1 PLACE OF DEATH a COUNTY <u>Wicomico</u> MARYLAND		2 USUAL RESIDENCE (Where deceased lived If institution; Residence before admission) a STATE <u>MD</u> b COUNTY <u>Wicomico</u>	
b CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Salisbury</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Tyaskin</u>	
d NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Peninsula Gen. Hospital</u>		e IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3 NAME OF DECEASED (Type or print) <u>Glady's T. Gattis</u>		4. DATE OF DEATH <u>November 24 1960</u>	
5 SEX <u>F</u>	6. COLOR OR RACE <u>C</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8 DATE OF BIRTH <u>9/12/1902</u>
9 AGE (in years last birthday) <u>58</u> yrs		IF UNDER 1 YEAR <u>9</u> Months <u>12</u> Days	IF UNDER 24 HRS <u>9</u> Hours <u>15</u> Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10b. KIND OF BUSINESS OR INDUSTRY <u>MD.</u>	11 BIRTHPLACE (State or foreign country) <u>U.S.</u>
12. FATHER'S NAME <u>John Wainwright</u>		14 MOTHER'S MAIDEN NAME <u>Evelyn Jones</u>	
15 WAS DECEASED EVER IN U S ARMED FORCES? (Yes, no if unknown) <u>No</u>		16 SOCIAL SECURITY NO. <u>219-05-3527</u>	
17. INFORMANT <u>Louise Wainwright</u>		Address <u>Tyaskin MD</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c)]		INTERVAL BETWEEN ONSET AND DEATH	
PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <u>BRONCHO-PNEUMONIA</u>		<u>3 weeks</u>	
Conditions if any, which gave rise to immediate cause (a), stating the underlying cause last (b) <u>Pulmonary Metastatic Carcinoma</u>		<u>3 months</u>	
(c) <u>Adenocarcinoma Breast</u>		<u>2 years</u>	
PART II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			
20a ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18)	
20c. TIME OF INJURY Month Day Year Hour a. m. p. m. <u>19</u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21 I certify that (I) (this hospital) attended the deceased from <u>17 NOV 1960</u> to <u>24 NOV 1960</u> that (I) (we) last saw the deceased alive on <u>24 Nov 1960</u> and that death occurred at <u>11:45</u> M, from the causes and on the date stated above			
22a SIGNATURE <u>Richard H. Saunders</u> M D		22b DATE SIGNED <u>11/25/60</u>	
22c ADDRESS <u>NANTICORE MD</u>			
23a BURIAL, CREMATION, REMOVAL (Specify) <u>11/27/60</u>		23b DATE THEREOF <u>11/27/60</u>	
23c NAME OF CEMETERY OR CREMATORY <u>Tyaskin Cem.</u>		23d LOCATION (City, town, or county) (State) <u>Tyaskin, MD.</u>	
24 FUNERAL DIRECTOR'S SIGNATURE <u>C. J. Messing, Biville, MD.</u>		25a REC'D BY REGISTRAR <u>NOV 28 '60</u>	
		25b REGISTRAR'S SIGNATURE <u>Arthur S. Kneass</u>	

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13181

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND
CERTIFICATE OF DEATH

13160

1. PLACE OF DEATH a. COUNTY <u>Harford</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution Residence before admission) a. STATE <u>MD</u> b. COUNTY <u>Mic.</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Danbury</u>		c. LENGTH OF STAY IN 1b <u>18 yrs</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Belmon</u>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Peninsula General Hospital</u>				d. STREET ADDRESS <u>1</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) <u>Rufus</u> First Middle Last				4. DATE OF DEATH Month <u>November</u> Day <u>5</u> Year <u>1960</u>			
5. SEX <u>male</u>	6. COLOR OR RACE <u>Ne. GRD</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>Mar 14 1888</u>	9. AGE (in years last birthday) <u>72</u> yrs	IF UNDER 1 YEAR Months <u>—</u> Days <u>—</u> Hours <u>—</u> Min <u>—</u>	IF UNDER 24 HRS Months <u>—</u> Days <u>—</u> Hours <u>—</u> Min <u>—</u>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life even if retired) <u>Labor</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>none</u>		11. BIRTHPLACE (State or foreign country) <u>VA</u>		12. CITIZEN OF WHAT COUNTRY? <u>EX 5 A</u>	
13. FATHER'S NAME <u>Unknown</u>				14. MOTHER'S MAIDEN NAME <u>Unknown</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown. If yes, give war or dates of service) <u>—</u>		16. SOCIAL SECURITY NO <u>214-36-5287</u>		17. INFORMANT <u>Annice Bohorn</u>		Address <u>Belmon</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b) and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Encephalomalacia</u> DUE TO Conditions, if any which gave rise to immediate cause (a), stating the underlying cause lost. (b) <u>Thrombosis middle cerebral artery aft</u> DUE TO (c) <u>Arteriosclerotic C. V. D.</u>						INTERVAL BETWEEN ONSET AND DEATH <u>15 Days</u> <u>15 Days</u> <u>?</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>None</u>						19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18)					
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <u>19</u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from <u>10/25/60</u> 19 <u>5</u> to <u>11/5/60</u> 19 <u>—</u> , that (I) (we) last saw the deceased alive on <u>11/5/60</u> 19 <u>—</u> , and that death occurred at <u>12 P.M.</u> from the causes and on the date stated above.							
22a. SIGNATURE <u>Joseph C. Fitzgerald M.D.</u>				M.D. ATTENDING PHYS <input type="checkbox"/> MED DIRECTOR <input type="checkbox"/> STAFF PHYS <input type="checkbox"/>		22b. DATE SIGNED	
22c. PHYSICIAN'S NAME (Type)				22d. ADDRESS			
23a. BURIAL CREMATION REMOVAL (Specify)		23b. DATE THEREOF		23c. NAME OF CEMETERY OR CREMATORY		23d. LOCATION (City, town, or county) (State)	
<u>Burial</u>		<u>11-8-60</u>		<u>Union Cem</u>		<u>Belmon MD</u>	
24. FUNERAL DIRECTOR'S SIGNATURE <u>Booker M West</u>				ADDRESS		25a. REC'D BY REGISTRAR DATE <u>NOV 9 60</u>	
						25b. REGISTRAR'S SIGNATURE <u>Charles S. Hines</u>	



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that this death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, the funeral director, page 3 should be detached for use as the burial transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Board of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

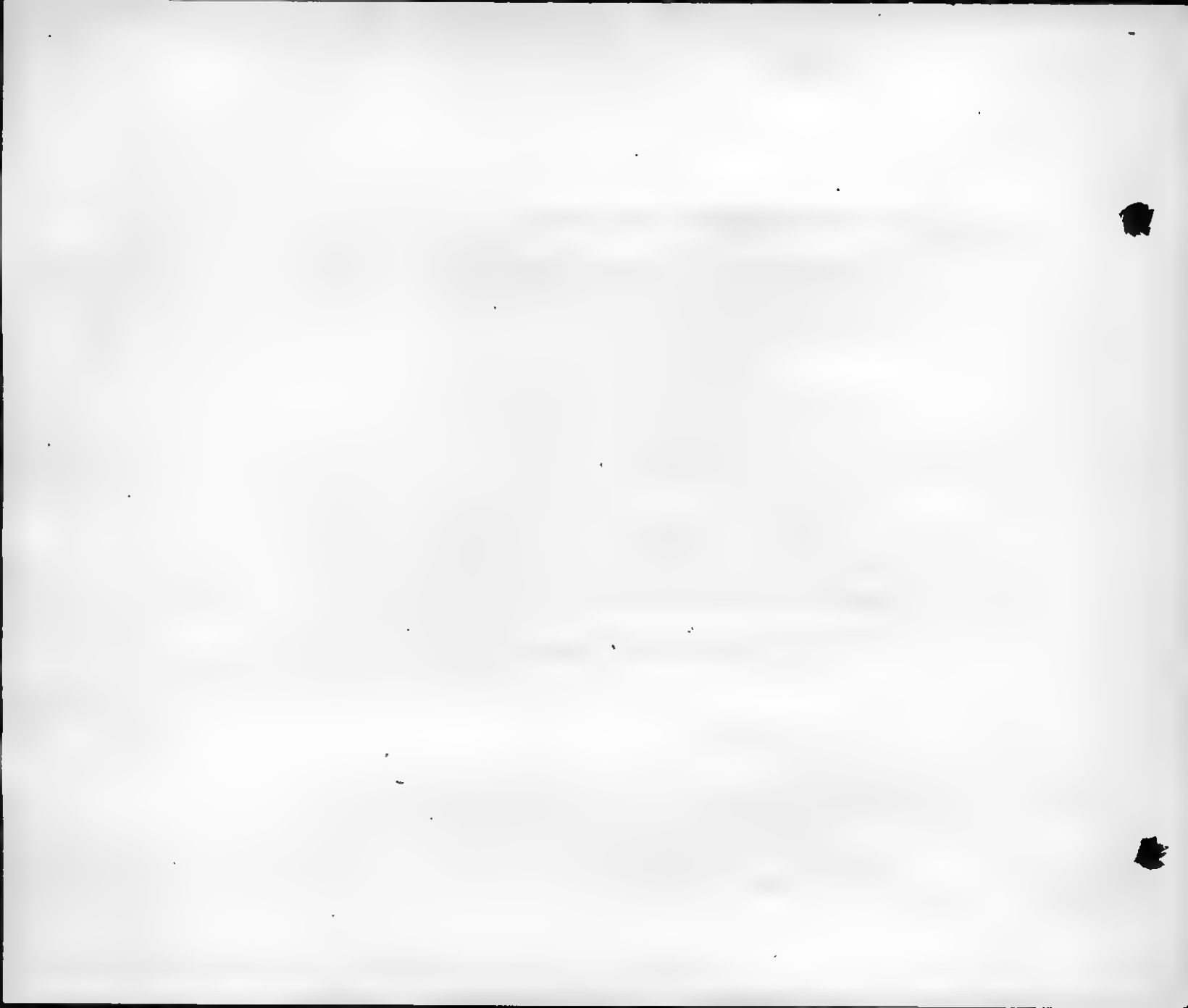
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ISM 9/59

13182

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND
CERTIFICATE OF DEATH

13161

1. PLACE OF DEATH a. COUNTY <u>Wicomico</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institut on Residence before admission) a. STATE <u>MARYLAND</u> b. COUNTY <u>WORCESTER</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Salisbury</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Pocomoke City</u>	
c. LENGTH OF STAY IN 1b <u>5 DAYS</u>		d. STREET ADDRESS <u>11 CENTRAL AVENUE</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>PENINSULA General Hospital</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Middle Last <u>MAURICE WILLIAM Gray</u>		4. DATE OF DEATH Month Day Year <u>November 1 - 1960</u>	
5. SEX <u>male</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>OCT. 21, 1902</u>
9. AGE (In years last birthday) <u>58</u> yrs.		IF UNDER 1 YEAR IF UNDER 24 HRS Months Days Hours Min	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>CONDUCTOR</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>RAILROAD</u>	
11. BIRTHPLACE (State or foreign country) <u>MARYLAND</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA.</u>	
13. FATHER'S NAME <u>EDWARD GRAY</u>		14. MOTHER'S MAIDEN NAME <u>JENNIE MASON</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>NO</u>		16. SOCIAL SECURITY NO. <u>—</u>	
17. INFORMANT Address <u>MRS ADA B. GRAY, 11 CENTRAL AVENUE, POCOMOKE CITY, MD.</u>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c)] PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <u>Coronary Artery Thrombosis</u> DUE TO <u>Coronary Atherosclerosis</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <u>—</u> (c) <u>—</u>		INTERVAL BETWEEN ONSET AND DEATH <u>3 days</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>Pulmonary emphysema & fibrosis; Mesenteric Thrombosis</u>		19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18)	
20c. TIME OF INJURY Month Day Year Hour a. m. p. m. <u>19</u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from <u>11-1-1960</u> to <u>11-7-1960</u> that (I) (we) last saw the deceased alive on <u>19</u> , and that death occurred at <u>9:34</u> M, from the causes and on the date stated above.			
22a. SIGNATURE <u>David J. Gilmore</u>		22b. DATE SIGNED <u>11/7/60</u>	
22c. PHYSICIAN'S NAME (Type) <u>DAVID J. GILMORE</u>		22d. ADDRESS <u>SALISBURY, MARYLAND</u>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>BURIAL</u>		23b. DATE THEREOF <u>11-8-60</u>	
23c. NAME OF CEMETERY OR CREMATORY <u>SALEM METHODIST</u>		23d. LOCATION (City, town, or county) (State) <u>POCOMOKE CITY, MARYLAND</u>	
24. FUNERAL DIRECTOR'S SIGNATURE <u>Henry H. Watson</u>		25a. REC'D BY REGISTRAR <u>DATE NOV 9 '60</u>	
ADDRESS <u>POCOMOKE CITY, MD.</u>		25b. REGISTRAR'S SIGNATURE <u>Charles E. Kinn</u>	



1
Maryland State Department of Health
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND
CERTIFICATE OF DEATH

13162

13183

1 PLACE OF DEATH a COUNTY Wicomico MARYLAND		2 USUAL RESIDENCE (Where deceased lived If institution Residence before admission) a STATE Maryland b COUNTY Wicomico	
b CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Salisbury		c LENGTH OF STAY IN 1b	
d NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION 610 S.Division St		d STREET ADDRESS 610 S.Division St	
3 NAME OF DECEASED (Type or print) First Middle Last HARLAND B HOLLOWAY		4 DATE OF DEATH Month Day Year NOVEMBER 29th 1960	
5 SEX Male	6 COLOR OR RACE White	7 MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> Single	8 DATE OF BIRTH June 2, 1903
9 AGE (In years lost birthday) yrs 57		10 IF UNDER 1 YEAR Months Days Hours Min	
10a USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Auto Mechanic		10b KIND OF BUSINESS OR INDUSTRY Operator of Own Garage	
11 BIRTHPLACE (State or foreign country) Delmar, Maryland		12 CITIZEN OF WHAT COUNTRY? U S A	
13 FATHER'S NAME Caldwell F. Holloway		14 MOTHER'S MAIDEN NAME Ada A. Hastings	
15 WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No		16 SOCIAL SECURITY NO	
17 INFORMANT Address Mrs. Ada A. Holloway (Mother) 610 S. Div. St Salisbury, Maryland			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) gastrointestinal hemorrhage 151X DUE TO Conditions if any, which gave rise to immediate cause (c), stating the underlying cause lost. (b) Carcinoma of Stomach DUE TO (c) INTERVAL BETWEEN ONSET AND DEATH 8 hours 3 yr.			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			19 WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)		20b DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18) N/A	
20c TIME OF INJURY Month, Day, Year Hour a. m. p. m. N/A 19	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) N/A	20f (City or town) (County) (State) N/A
21 I certify that (I) (this hospital) attended the deceased from Sept 2, 1959 to Nov. 29, 1960 that (I) (we) last saw the deceased alive on Nov 28 1960 , and that death occurred on Nov 29 1960 at 2:00 PM , from the causes and on the date stated above.			
22a SIGNATURE [Signature]		22b DATE SIGNED Nov. 29 1960	
22c PHYSICIAN'S NAME (Type) Dr. Robert T. Adkins		22d ADDRESS Fruitland, Maryland	
23a BURIAL CREMATION, REMOVAL (Specify) Burial	23b DATE THEREOF Dec. 1, 1960	23c NAME OF CEMETERY OR CREMATORY Forest Grove Cemetery-R.D.#	23d LOCATION (City, town, or county) (State) Parsonsborg, Md.
24 FUNERAL DIRECTOR'S SIGNATURE HOLLOWAY & COMPANY		25a REC'D BY REGISTRAR DEC 1 '60	
ADDRESS SALISBURY MARYLAND		25b REGISTRAR'S SIGNATURE [Signature]	



13222 CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH				2. USUAL RESIDENCE (HOME) OF DECEASED			
COUNTY <u>Wicomico</u>		STATE <u>Md.</u> COUNTY <u>Wicomico</u>		CITY (If outside corporate limits, write RURAL and give nearest town)		TOWN <u>Mardela</u>	
CITY (If outside corporate limits, write RURAL and give nearest town)		LENGTH OF STAY (in this place)		CITY (If outside corporate limits, write RURAL and give nearest town)		TOWN <u>Mardela</u>	
TOWN <u>Mardela</u>		<u>84 yrs</u>		STREET ADDRESS (If rural give location)		ADDRESS <u>Bridge St. & Athol</u>	
HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>Bridge St. & Athol</u>				STREET ADDRESS <u>Bridge St. & Athol</u>			
3. NAME OF DECEASED (Type or Print)				4. DATE OF DEATH			
(First) <u>Cora</u> (Middle) <u>Elizabeth</u> (Last) <u>Jenkins</u>				(Month) <u>Nov</u> (Day) <u>14</u> (Year) <u>1960</u>			
5. SEX <u>M</u>	6. COLOR OR RACE <u>White</u>	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) <u>Widow</u>	8. DATE OF BIRTH <u>Oct 2, 1876</u>	9. AGE last birthday <u>84</u> yrs.	IF UNDER 1 YEAR		IF UNDER 24 HRS.
				Months		Days	Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>postmistress</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>U.S. Govt.</u>		11. BIRTHPLACE (State or foreign country) <u>Md.</u>		12. CITIZEN OF WHAT COUNTRY? <u>U. S.</u>	
13. FATHER'S NAME <u>Noah Bennett</u>				14. MOTHER'S MAIDEN NAME <u>Mary Bradley</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unk.) <u>No</u>		16. SOCIAL SECURITY NO. <u>No</u>		17. INFORMANT & ADDRESS <u>Mrs. Florence Jenkins, Mardela, Md.</u>			
I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH				18. MEDICAL CERTIFICATION			
IMMEDIATE CAUSE (A) <u>Ischemic Heart Disease</u>				INTERVAL BETWEEN ONSET AND DEATH <u>7 day</u>			
ANTECEDENT CAUSE(S) DUE TO							
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE							
STATING UNDERLYING CAUSE LAST. DUE TO							
(C)							
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.							
19a. DATE OF OPERATION		19b. MAJOR FINDINGS OF OPERATION		20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. PLACE (Home, farm, factory, of INJURY street, office bldg., etc.)		21c. WHERE DID INJURY OCCUR? (City or town) (County) (State)			
21d. TIME OF INJURY (Month) (Day) (Year) (Hour)		21e. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		21f. HOW DID INJURY OCCUR?			
22. I hereby certify that I attended the deceased from <u>Nov 7, 1960</u> , to <u>Nov 14, 1960</u> , that I last saw the deceased alive on <u>Nov 14, 1960</u> , and that death occurred at <u>1 P</u> M, from the causes and on the date stated above.							
SIGNATURE <u>H. S. Kuhlman</u>				ADDRESS (Street, city, town, state) <u>8 Harpton Rd Mardela, Md.</u>		DATE SIGNED <u>11/15/60</u> (State)	
23. BURIAL, CREMATION, REMOVAL (SPECIFY) <u>1</u>		DATE THEREOF <u>Nov 17-60</u>		NAME OF CEMETERY OR CREMATORY <u>Mardela</u>		LOCATION (City, town, or county) <u>Mardela, Md.</u>	
24. REC'D BY REGISTRAR		REGISTRAR'S SIGNATURE <u>Charles S. Kuhlman</u>		25. FUNERAL DIRECTOR'S SIGNATURE		ADDRESS	
DATE <u>NOV 18 '60</u>				<u>John W. Harpton</u>			

INSTRUCTIONS

TO ATTENDING PHYSICIAN OR HOSPITAL: The law requires that the death certificate be executed within 24 hours after death. The bottom copy may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: The law requires that the death certificate be filed with the registrar within 72 hours after death. After this certificate has been executed by the attending physician and completely filled in by the funeral director, the third copy of this death certificate assembly should be detached for use as a burial transit permit.

VS A15C 1-55 10M



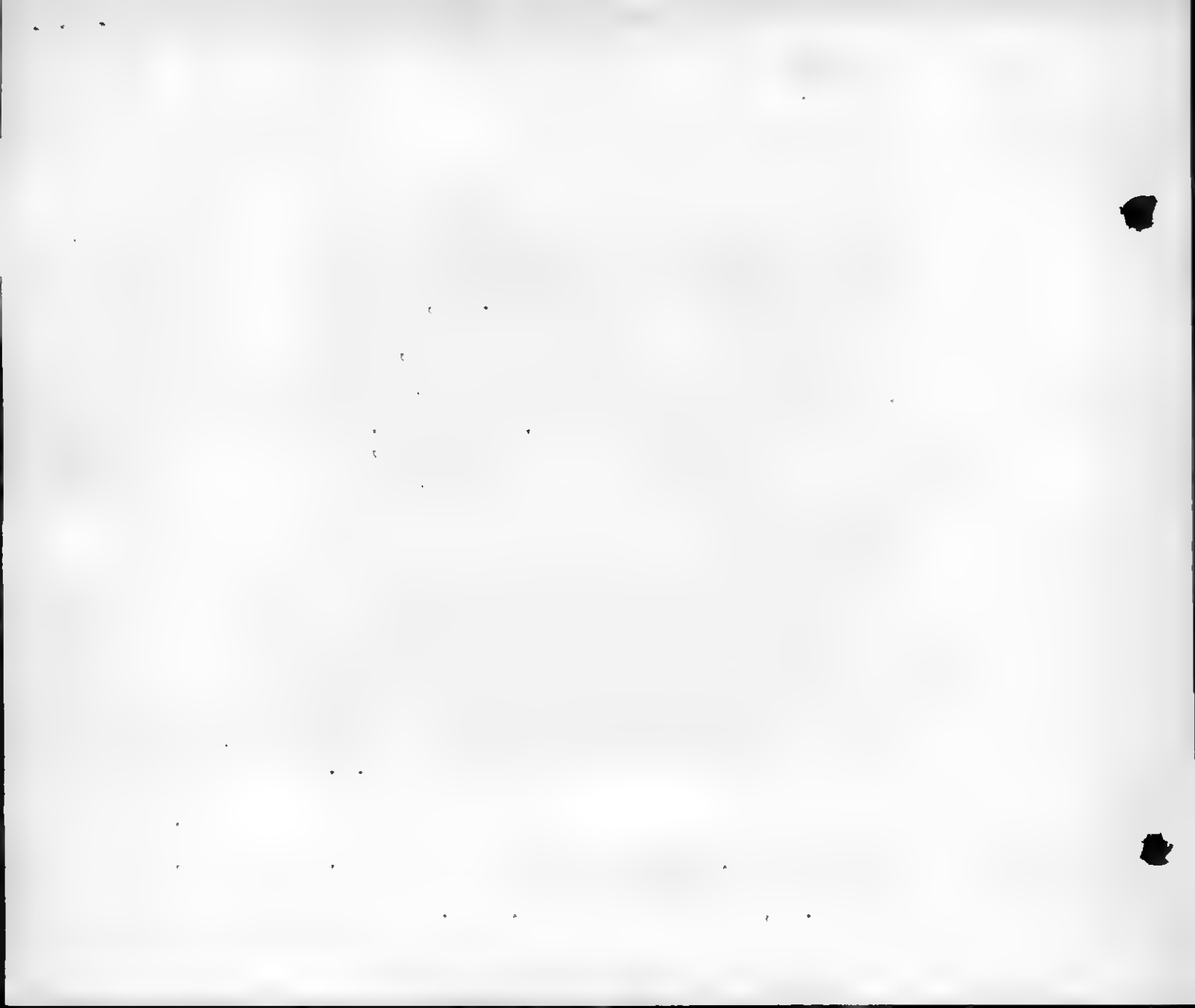
MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND
CERTIFICATE OF DEATH

13164

13184

1. PLACE OF DEATH a. COUNTY Wicomico MARYLAND				2. USUAL RESIDENCE [Where deceased lived If institution Residence before admission] a. STATE Maryland b. COUNTY Wicomico			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Salisbury			c. LENGTH OF STAY IN 1b			c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Salisbury	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION 301 Pond St				d. STREET ADDRESS 301 Pond St		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First DEBBIE Middle MARY Last MURLEY				4. DATE OF DEATH Month NOVEMBER Day 19 Year 1960			
5. SEX Female		6. COLOR OR RACE White		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH Oct. 20, 1983	
9. AGE (In years last birthday) 77 yrs.		IF UNDER 1 YEAR Months 0 Days 9		IF UNDER 24 HRS Hours Min 			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) House Work at Home		10b. KIND OF BUSINESS OR INDUSTRY None		11. BIRTHPLACE (State or foreign country) Seaford, Delaware		12. CITIZEN OF WHAT COUNTRY? U S A	
13. FATHER'S NAME James A. Wilson				14. MOTHER'S MAIDEN NAME Matilda Lingo			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) No		16. SOCIAL SECURITY NO. 		17. INFORMANT Dr. Benjamin F. Hurley (Address Salisbury, Maryland)			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) 450.0 Cerebral Arteriosclerosis DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) DUE TO (c) 							INTERVAL BETWEEN ONSET AND DEATH
PART II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 							19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18) N/A					
20c. TIME OF INJURY Month, Day, Year Hour a. m. N/A p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) N/A		20f. (City or town) N/A (County) (State) 	
21. I certify that (I) (this hospital) attended the deceased from 11/8/60 19 to 11/19/60 19, that (I) (we) last saw the deceased alive on 11/16/60 19, and that death occurred at 3:10 P.M. from the causes and on the date stated above							
22a. SIGNATURE Dr. Andrew C. Mitchell				M.D. ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22b. DATE SIGNED NOV. 21 / 1960	
22c. PHYSICIAN'S NAME (Type) Dr. Andrew C. Mitchell				22d. ADDRESS Marvyn Ave. Salisbury, Maryland			
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE THEREOF Nov. 22, 1960		23c. NAME OF CEMETERY OR CREMATORY Wicomico Mem. Park.		23d. LOCATION (City, town, or county) (State) Salisbury, Maryland	
24. FUNERAL DIRECTOR'S SIGNATURE HOLLANDAY & COMPANY				ADDRESS SALISBURY MARYLAND		25a. REC'D BY REGISTRAR NOV 22 '60	
				25b. REGISTRAR'S SIGNATURE Arthur S. Hanna			

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Board of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS A15 (4)
15M 9/58

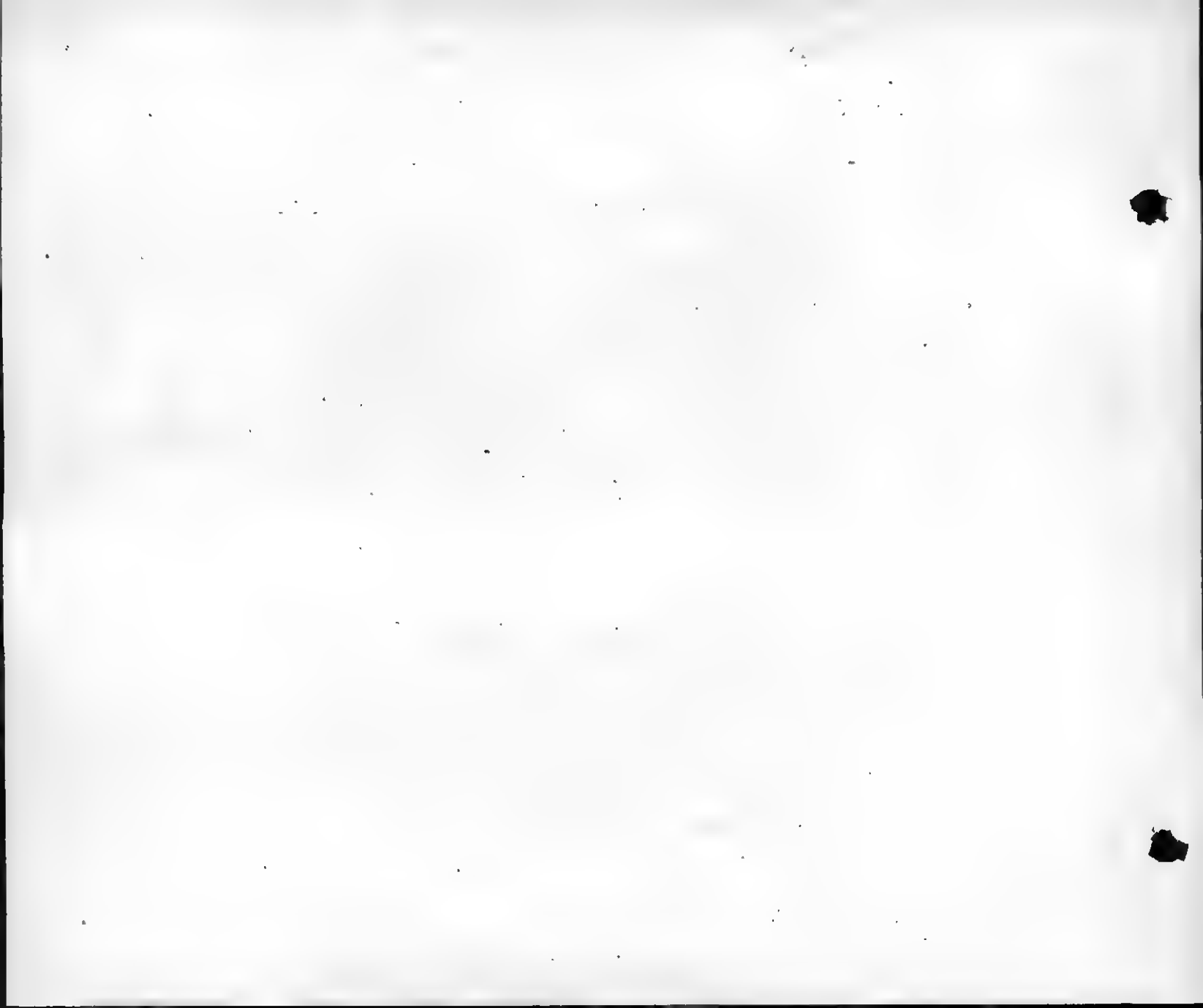
13185

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

CERTIFICATE OF DEATH

Reg. Dist. No. 13165

1. PLACE OF DEATH a. COUNTY Wicomico MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution. Residence before admission) a. STATE Maryland b. COUNTY Wicomico	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Salisbury		c. LENGTH OF STAY IN 1b	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Seminole & Shawnee		e. STREET ADDRESS Seminole & Shawnee	
3. NAME OF DECEASED (Type or print) First Annie Middle Jackson Last Jackson		4. DATE OF DEATH Month November , Day 26 , Year 1960	
5. SEX F.	6. COLOR OR RACE C.	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH September 4, 1863
9. AGE (In years lost birthday) 97 yrs.		10. IF UNDER 1 YEAR IF UNDER 24 HRS Months 10 Days 15 Hours 15 Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Domestic		10b. KIND OF BUSINESS OR INDUSTRY	
11. BIRTHPLACE (State or foreign country) Maryland		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME Columbus Crawford		14. MOTHER'S MAIDEN NAME Nicie Burris	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) No		16. SOCIAL SECURITY NO. 420.0	
17. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) arteriosclerotic Heart Disease 420.0 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) Cardiac failure (c) 152		INTERVAL BETWEEN ONSET AND DEATH 10 yrs	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) chronic pneumonia Right lower lobe			
18. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. TIME OF INJURY Month, Day, Year Hour o. m. 19 p. m.		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18)	
20c. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20d. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20e. (City or town)		(County) (State)	
21. I certify that I attended the deceased from 11/2 , 19 51 , to death , 19 60 , that I last saw the deceased alive on 11/2 , 19 60 , and that death occurred at 730 PM , from the causes and on the date stated above.			
ACTUAL SIGNATURE Ernest M. Larmo M.D.		ADDRESS (Street, city or town, state) 120 Grove St. Delmar, Del.	
DATE SIGNED 12/1/60			
PHYSICIAN'S NAME (Type) E. M. LARMO RE			
22a. BURIAL, CREMATION, REMOVAL (Specify) burial 11/30/1960		22b. DATE THEREOF	
22c. NAME OF CEMETERY OR CREMATORY union		22d. LOCATION (City, town, or county) (State) Delmar Md.	
23. FUNERAL DIRECTOR'S SIGNATURE Clinton B. Stewart Salisbury Md.		24a. REC'D BY REGISTRAR DATE DEC 5 '60	
24b. REGISTRAR'S SIGNATURE William S. Hearn			



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be examined within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, the funeral director, page 3 must be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Board of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

13186

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND
CERTIFICATE OF DEATH

13166

1. PLACE OF DEATH a. COUNTY <u>Wicomico</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Wicomico</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Salisbury</u>				c. LENGTH OF STAY IN 1b <u>1</u>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>307 Ohio Ave</u>				d. STREET ADDRESS <u>307 Ohio Ave.</u>			
3. NAME OF DECEASED (Type or print) First Middle Last <u>CHARLES LEE JOHNSON</u>				4. DATE OF DEATH Month Day Year <u>NOVEMBER 3rd 19 60</u>			
5 SEX <u>Male</u>	6 COLOR OR RACE <u>White</u>	7 MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8 DATE OF BIRTH <u>April 1, 1874</u>		9 AGE (In years last birthday) <u>86</u> yrs	10a USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Retired Furniture Salesman</u>	
10b KIND OF BUSINESS OR INDUSTRY <u>Worcester Co., Maryland</u>				12 CITIZEN OF WHAT COUNTRY? <u>U S A</u>			
13. FATHER'S NAME <u>James Johnson</u>				14. MOTHER'S MAIDEN NAME <u>Mary Elizabeth Shockley</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (If yes, give war or dates of service) <u>No</u>				16. SOCIAL SECURITY NO. <u>N/A</u>			
17. INFORMANT <u>Mrs. Harriet Bolderson (Daughter)</u>				Address <u>307 Ohio Ave., Salisbury, Maryland</u>			
18 CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <u>Stroke</u> DUE TO (b) <u>C. V. A.</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost (c) <u>Thrombosis</u> PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>N/A</u>						INTERVAL BETWEEN ONSET AND DEATH	
20a ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) <u>N/A</u>				20b DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) <u>N/A</u>			
20c TIME OF INJURY Month, Day, Year Hour a. m. p. m. <u>N/A 19</u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <u>N/A</u>		20f. (City or town) (County) (State) <u>N/A</u>	
21 I certify that (I) (this hospital) attended the deceased from <u>11/2 1960</u> to <u>11/3 1960</u> , that (I) was last saw the deceased alive on <u>11/3 1960</u> , and that death occurred at <u>4:30</u> M. from the causes and on the date stated above.							
22a. SIGNATURE <u>Dr. William B. Smith</u>				22b DATE SIGNED <u>Nov. 4 1960</u>			
22c PHYSICIAN'S NAME (Type) <u>Dr. William B. Smith</u>				22d ADDRESS <u>Salisbury, Maryland</u>			
23a BURIAL CREMATION, REMOVAL (Specify) <u>Burial</u>		23b DATE THEREOF <u>Nov. 5, 1960</u>		23c NAME OF CEMETERY OR CREMATORY <u>Whitcomb Cemetery</u>		23d LOCATION (City, town or county) (State) <u>Snow Hill, Maryland</u>	
24. FUNERAL DIRECTOR'S SIGNATURE <u>HOLLIDAY & COMPANY</u>				ADDRESS <u>SALISBURY MARYLAND</u>		25a. REC'D BY REGISTRAR <u>NOV 7 '60</u>	
				25b REGISTRAR'S SIGNATURE <u>Arthur S. Kline</u>			



1
FOR STATE
HEALTH DEPT.

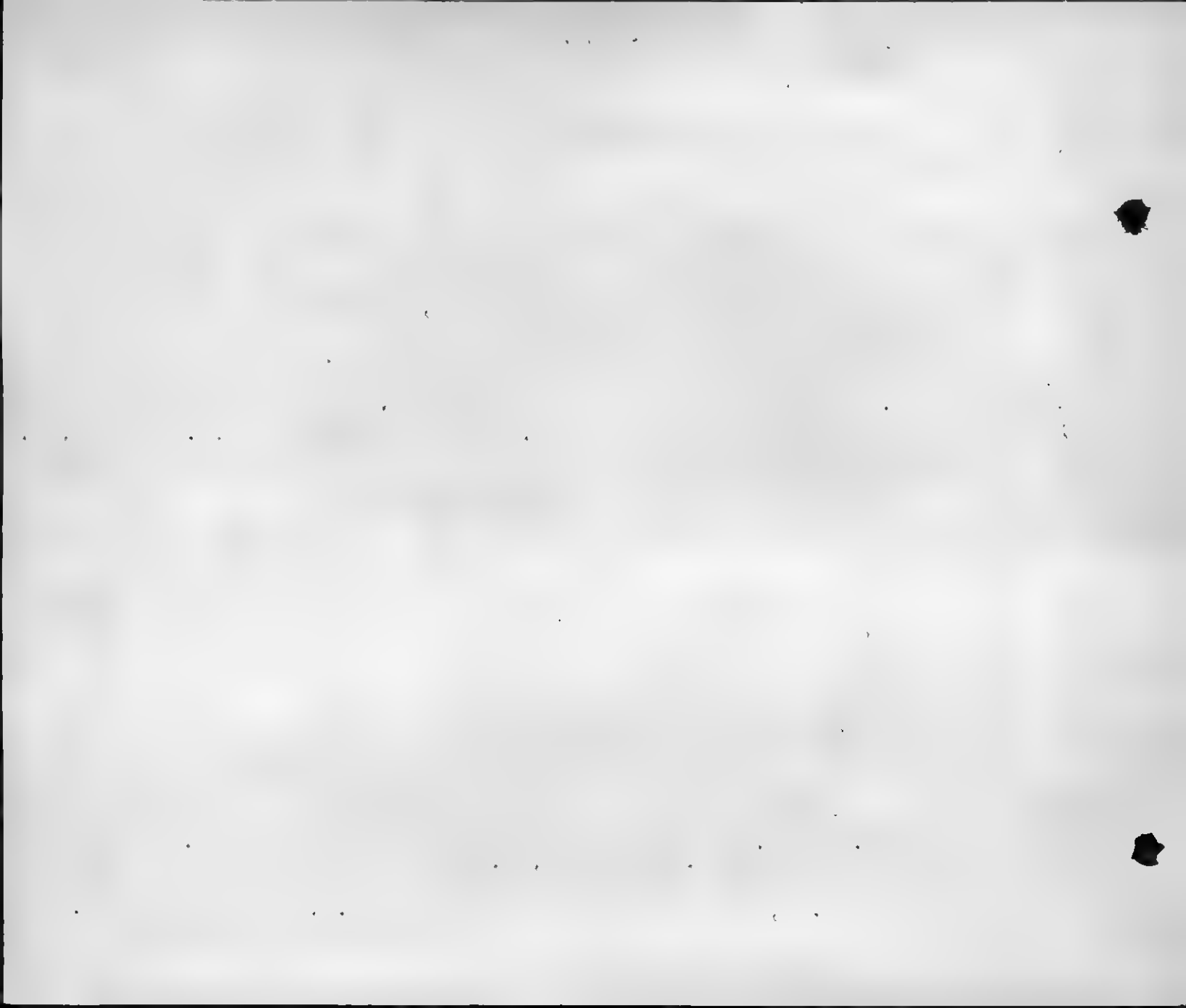
TO DETECT MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any is necessary, please execute the certificate, writing the word "pending" in pencil in 18. Give pages 1, 2, and 3 to the Medical Director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS. A15ME
5M 7/59

13187 MARYLAND STATE DEPARTMENT OF HEALTH
Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND
13167 MEDICAL EXAMINER'S CERTIFICATE OF DEATH

1. PLACE OF DEATH a. COUNTY <u>Wicomico</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if not within residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Wicomico</u>	
b. CITY OR TOWN (If out of corporate limits, write RURAL and give nearest town) <u>Salisbury</u>		c. CITY OR TOWN (If out of corporate limits, write RURAL and give nearest town) <u>Salisbury</u>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>Charles Ford State Hospital</u>		d. STREET ADDRESS <u>417 Patterson Ave</u>	
3. NAME OF DECEASED (Type or print) <u>LITTLE VIRGILIA JETTER</u>		4. DATE OF DEATH <u>NOV - 4 1960</u>	
5. SEX <u>Female</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> D. VORCED <input checked="" type="checkbox"/>	8. DATE OF BIRTH <u>Feb 1, 1906</u>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>house work at home</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>None</u>	
11. BIRTHPLACE (State or foreign country) <u>Forrester Co. Maryland</u>		12. CITIZEN OF WHAT COUNTRY? <u>U S A</u>	
13. FATHER'S NAME <u>Ernest J. Griffin</u>		14. MOTHER'S MAIDEN NAME <u>Sallie M. (Branch) Dykes</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give year or dates of service) <u>No</u>		16. SOCIAL SECURITY NO. <u>Mr. William Kelley (Son)</u>	
17. INFORMANT <u>Mr. William Kelley (Son)</u>		18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Broncho pneumonia</u> 904-0 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>Fracture Rt. Hip</u>	
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING CAUSE OF DEATH. <input checked="" type="checkbox"/>		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of Item 18.) <u>Fall of Home</u>	
20c. TIME OF INJURY Month, Day, Year <u>10-26-1960</u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input checked="" type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <u>Home</u>		20f. (City or town) <u>Salisbury</u> (County) <u>Wicomico</u> (State) <u>MD</u>	
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from: Natural causes <input type="checkbox"/> Accident <input checked="" type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>			
ACTUAL SIGNATURE <u>Dr. Earl L. Royer</u> M.D.		CHIEF MEDICAL EXAMINER <input type="checkbox"/>	
EXAMINER'S NAME (Type) <u>Dr. Earl L. Royer</u>		ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>burial</u>		22b. DATE THEREOF <u>Nov. 16, 1960</u>	
22c. NAME OF CEMETERY OR CREMATORY <u>St. Paul's Church Cemetery</u>		22d. LOCATION (City, town, or country) <u>P. O. # 4 Benson, Md.</u>	
23. FUNERAL DIRECTOR <u>HOLLAND & COMPANY</u>		ADDRESS <u>SALISBURY MARYLAND</u>	
24a. REC'D BY REGISTRAR <u>NOV 16 '60</u>		24b. REGISTRAR'S SIGNATURE <u>William S. Frank</u>	

DATE SIGNED
Nov. 15 / 1960



TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any day is necessary, please execute the certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

FOR STATE
HEALTH DEPT.

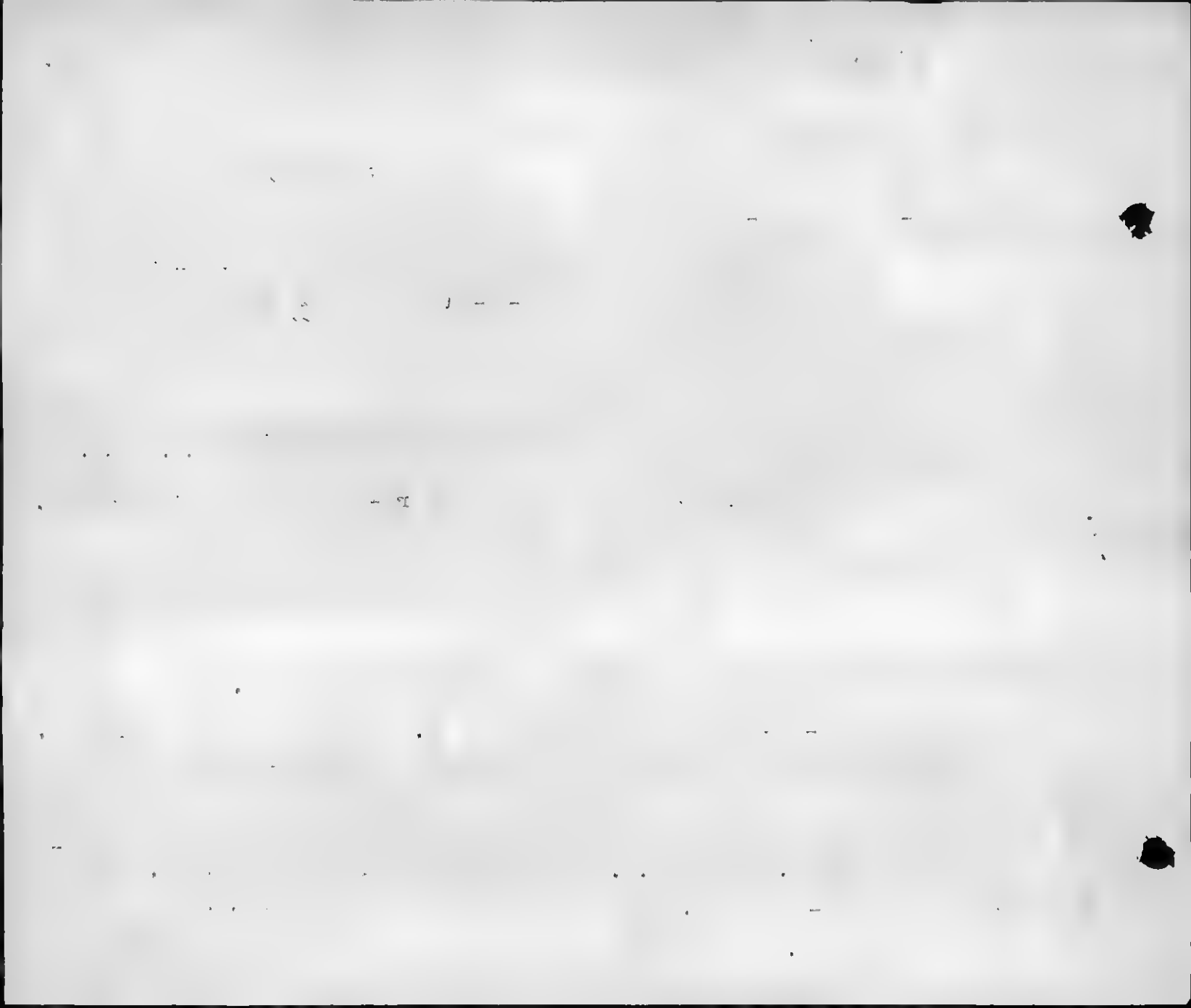
MARYLAND STATE DEPARTMENT OF HEALTH

Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

13188 MEDICAL EXAMINER'S CERTIFICATE OF DEATH

13168

1. PLACE OF DEATH a. COUNTY Wicomico b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Salisbury c. LENGTH OF STAY IN b 1 Day d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) Aboard- Freighter-Consul Horn		2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) a. STATE MARYLAND c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Wilhelmshafen, Germany d. STREET ADDRESS 37X-1	
3. NAME OF DECEASED (Type or print) Calo Alvin KUFFNER 4. DATE OF DEATH 11-28-60		5. SEX M 6. COLOR OR RACE W 7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> 8. DATE OF BIRTH 12-13-1900	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Chief Engineer		10b. KIND OF BUSINESS OR INDUSTRY Shipping	
11. BIRTHPLACE (State or foreign country) Hamburg, Germany		12. CITIZEN OF WHAT COUNTRY? Germany	
13. FATHER'S NAME Unknown		14. MOTHER'S MAIDEN NAME Unknown	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) Unknown ***		16. SOCIAL SECURITY NO. None	
17. INFORMANT Consul Horn Freighter records (Passport) Caravel Shipping, 26 Broadway N.Y. 4 N.Y.		18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) Fractured skull with intra-cranial hemorrhage- Min. 901.8 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I. 19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
20a. EXTERNAL CAUSE WAS PRIMARY <input checked="" type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH 20c. TIME OF INJURY Month, Day, Year 11-28-60 Hour a.m. 11-28-60 p.m. 11-28-60		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) Fell down ladder to engine room. 20d. INJURY OCCURRED While <input checked="" type="checkbox"/> Not While <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/> 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) Aboard ship, Salisbury Wicomico Md. 20f. (City or town) (County) (State)	
21. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from: Natural causes <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input checked="" type="checkbox"/>		CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>	
ACTUAL SIGNATURE Earl L. Royer, M.D. EXAMINER'S NAME (Type) Earl L. Royer, M.D.		DATE SIGNED 11-30-60	
22a. BURIAL, CREMATION, REMOVAL (Specify) Cremation		22b. DATE THEREOF 12-1-1960	
22c. NAME OF CEMETERY OR CREMATORY J.W.M. Lee's Crematory		22d. LOCATION (City, town, or country) (State) Washington, D.C.	
23. FUNERAL DIRECTOR Hill & Johnson Co. Salisbury, Maryland		24a. REC'D BY REGISTRAR DEC 1 '60	
24b. REGISTRAR'S SIGNATURE Arthur S. Kraus			



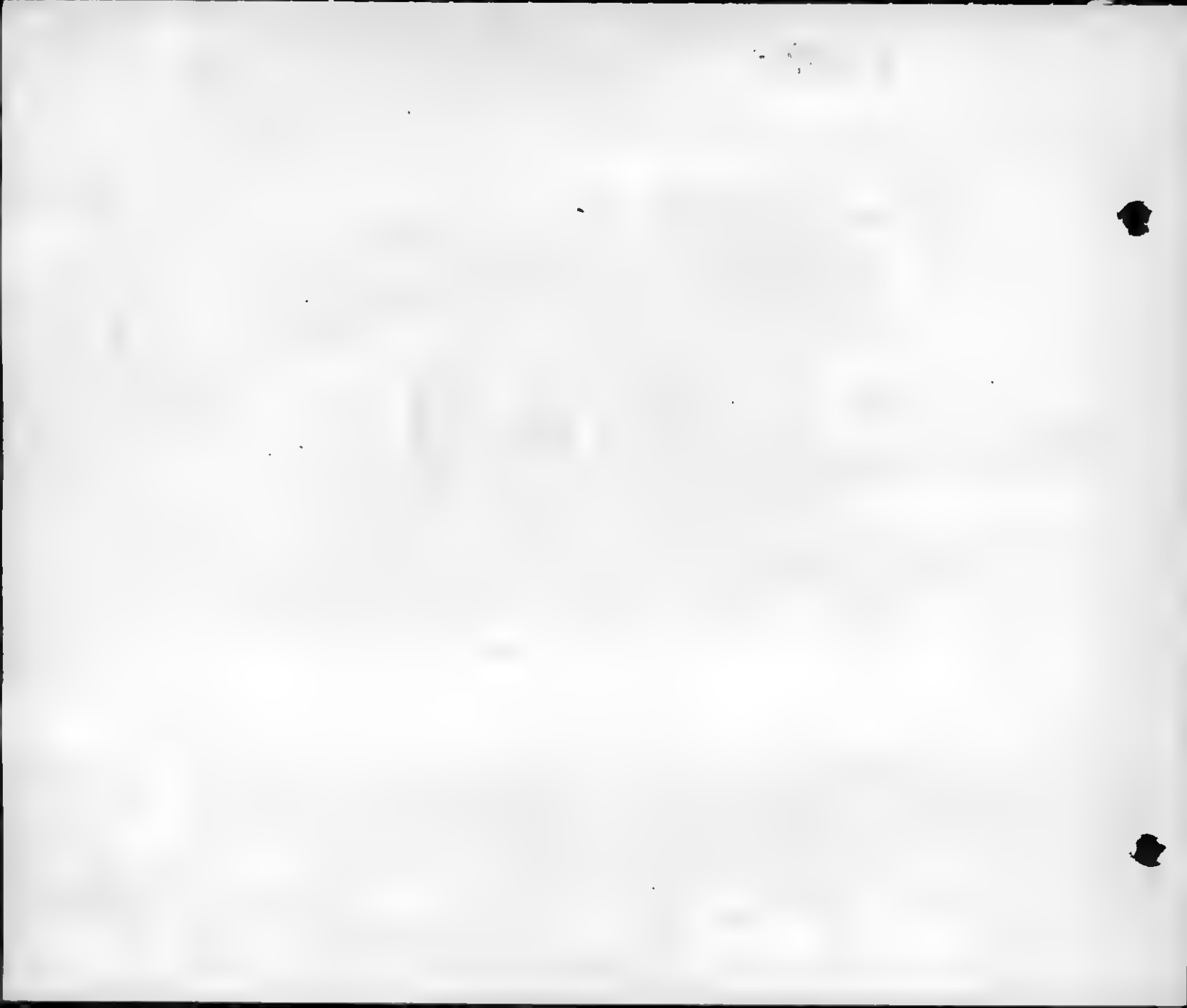
may be retained by the hospital or attending physician.
 TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Board of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

13189

MARYLAND STATE DEPARTMENT OF HEALTH
 DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND
CERTIFICATE OF DEATH

13169

1. PLACE OF DEATH a. COUNTY <u>Wicomico</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Md.</u> b. COUNTY <u>Somerset</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Salisbury</u>				c. LENGTH OF STAY IN 1b			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>General Hospital</u>				e. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Monie</u>			
f. STREET ADDRESS <u>14x-2</u>				g. RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First <u>Elizabeth</u> Middle <u>Lawson</u> Last <u>Lawson</u>				4. DATE OF DEATH Month <u>11</u> Day <u>12</u> Year <u>1960</u>			
5. SEX <u>F.</u>		6. COLOR OR RACE <u>W.</u>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>4/5/1876</u>	
9. AGE (In years last birthday) <u>84</u> yrs		10. IF UNDER 1 YEAR		11. IF UNDER 24 HRS		12. CITIZEN OF WHAT COUNTRY? <u>U.S.</u>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)				10b. KIND OF BUSINESS OR INDUSTRY			
11. BIRTHPLACE (State or foreign country) <u>Md.</u>				12. CITIZEN OF WHAT COUNTRY? <u>U.S.</u>			
13. FATHER'S NAME <u>George S. Lawson</u>				14. MOTHER'S MAIDEN NAME <u>Nancy Sterling</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) [If yes, give war or dates of service]				16. SOCIAL SECURITY NO			
17. INFORMANT <u>Mrs. Jack Bryan</u>				Address <u>Allen Md.</u>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c)]							
PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <u>422.2</u> DUE TO <u>Degenerative aortic disease</u>							
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) DUE TO (c)							
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18)			
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. <u>19</u>				20d. INJURY OCCURRED While of work <input type="checkbox"/> Not while at work <input type="checkbox"/>			
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)				20f. (City or town) (County) (State)			
21. I certify that (I) (this hospital) attended the deceased from <u>11-1</u> 19 <u>60</u> , to <u>11-12</u> 19 <u>60</u> that (I) (we) last saw the deceased alive on <u>11-12</u> 19 <u>60</u> , and that death occurred at <u>5</u> M, from the causes and on the date stated above.							
22a. SIGNATURE <u>W. S. Allen</u>				22b. DATE SIGNED <u>11-12-60</u>			
22c. PHYSICIAN'S NAME (Type) <u>W. S. Allen</u>				22d. ADDRESS <u>M.D.</u>			
23a. BURIAL, CREMATION REMOVAL (Specify) <u>Burial</u>		23b. DATE THEREOF <u>11/15/60</u>		23c. NAME OF CEMETERY OR CREMATORY <u>Oriole</u>		23d. LOCATION (City, town, or county) (State) <u>Oriole Md.</u>	
24. FUNERAL DIRECTOR'S SIGNATURE <u>James H. Hannon</u>				25a. REC'D BY REGISTRAR <u>NOV 28 '60</u>			
25b. REGISTRAR'S SIGNATURE <u>Arthur S. Hannon</u>							



TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Board of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

1
MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND
CERTIFICATE OF DEATH

13170

13190

1. PLACE OF DEATH a. COUNTY <u>WILMINGTON</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution, residence before admission) a. STATE <u>MARYLAND</u> b. COUNTY <u>WORCESTER</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>SHARPSBURG</u>				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>SHOWELL</u>			
d. NAME OF HOSPITAL (if not in hospital, give street address) OR INSTITUTION <u>PENNSYLVANIA GENERAL HOSPITAL</u>				d. STREET ADDRESS <u>2-2</u>			
3. NAME OF DECEASED (Type or print) First Middle Last <u>KATIE E. LECATES</u>				4. DATE OF DEATH Month Day Year <u>NOVEMBER 21 1960</u>			
5. SEX <u>FEMALE</u>	6. COLOR OR RACE <u>WHITE</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>AUG. 18, 1885</u>	9. AGE (In years last birthday) <u>75</u> yrs	F UNDER 1 YEAR Months Days	F UNDER 24 HRS. Hours Min	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>HOUSEWIFE</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>OWN HOME</u>		11. BIRTHPLACE (State or foreign country) <u>BERLIN, MARYLAND</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>EUGENE R. WAINWRIGHT</u>				14. MOTHER'S MAIDEN NAME <u>HESTER JARVIS</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) <u>NO</u>		16. SOCIAL SECURITY NO. <u>219-14-4974</u>		17. INFORMANT Address <u>MRS. LOU ANN SHOCKLEY BERLIN MD</u>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Acute Encephalitis</u> <u>072</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) DUE TO (c) DUE TO						INTERVAL BETWEEN ONSET AND DEATH <u>6 days</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)						19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day Year Hour a. m. p. m. <u>19</u>		20d. INJURY OCCURRED While of work <input type="checkbox"/> Not while of work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from <u>Nov. 16</u> 19 <u>60</u> to <u>Nov. 21</u> 19 <u>60</u> that (I) (we) last saw the deceased alive on <u>Nov. 21</u> 19 <u>60</u> , and that death occurred at <u>4:15</u> PM, from the causes and on the date stated above.							
22a. SIGNATURE <u>Arthur S. Kraus</u>				M.D. ATTENDING PHYS <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS <input type="checkbox"/>		22b. DATE SIGNED <u>11/21/60</u>	
22c. PHYSICIAN'S NAME (Type) <u>Arthur S. Kraus</u>				22d. ADDRESS			
23a. BURIAL CREMATION, REMOVAL (Specify) <u>BURIAL</u>		23b. DATE THEREOF <u>11/24/60</u>		23c. NAME OF CEMETERY OR CREMATORY <u>ODD FELLOWS</u>		23d. LOCATION (City, town, or county) (State) <u>BISHOPVILLE MD</u>	
24. FUNERAL DIRECTOR'S SIGNATURE <u>Anna A. Burbage</u>				25a. REC'D BY REGISTRAR DATE <u>NOV 28 60</u>		25b. REGISTRAR'S SIGNATURE <u>Arthur S. Kraus</u>	



1
FOR STATE
HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute in duplicate, writing the word "pending" in pencil in Item 18. Give Items 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.
TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. After pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS. A15ME
5M 7/59

(M)

(I)

MEDICAL CERTIFICATION

MARYLAND STATE DEPARTMENT OF HEALTH
Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

13191 MEDICAL EXAMINER'S CERTIFICATE OF DEATH 13171

<p>1. PLACE OF DEATH</p> <p>a. COUNTY <u>Wicomico</u> MARYLAND</p> <p>b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Salisbury</u></p> <p>c. LENGTH OF STAY IN b. _____</p> <p>d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>X. M. Pen. Gen. Hospital</u></p>		<p>2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission)</p> <p>a. STATE <u>Virginia</u> b. COUNTY _____</p> <p>c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Quantico</u></p> <p>d. STREET ADDRESS <u>(Marine Camp)</u></p> <p>e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/></p>	
<p>3. NAME OF DECEASED (Type or print) <u>PAUL HARRISON LORD</u></p> <p>5. SEX <u>Male</u> 6. COLOR OR RACE <u>White</u> 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> 8. DATE OF BIRTH <u>Mar. 14, 1940</u></p> <p>9. AGE (In years, last birthday) <u>20</u> yrs. <u>19</u> months <u>13</u> days <u>19</u> hours <u>60</u> min.</p>		<p>4. DATE OF DEATH <u>NOV 21 1960</u></p> <p>10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>U.S. Marines -Transportation-</u></p> <p>10b. KIND OF BUSINESS OR INDUSTRY _____</p> <p>11. BIRTHPLACE (State or foreign country) <u>Falls River, Mass</u></p> <p>12. CITIZEN OF WHAT COUNTRY? <u>U S A</u></p>	
<p>13. FATHER'S NAME <u>Alfred F. Lord</u></p> <p>14. MOTHER'S MAIDEN NAME <u>Dorothy I. Murray</u></p> <p>15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give year or dates of service) <u>Yes - 1960</u></p> <p>16. SOCIAL SECURITY NO. <u>Mr. Earl H. Lord (Father) 519 Salisbury, Maryland</u></p>		<p>17. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)</p> <p>PART I. DEATH WAS CAUSED BY:</p> <p>IMMEDIATE CAUSE (a) <u>Fracture dislocation of cervical spine</u></p> <p>CONDITIONS, IF ANY, WHICH GAVE RISE TO IMMEDIATE CAUSE (b) <u>F-23X</u></p> <p>UNDERLYING CAUSE (c) _____</p> <p>PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a), (b), and (c). _____</p> <p>19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/></p>	
<p>20a. EXTERNAL CAUSE WAS PRIMARY <input checked="" type="checkbox"/> CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.</p> <p>20c. TIME OF INJURY Month, Day, Year <u>12:10 a.m. / 12 / 1960</u></p> <p>20d. INJURY OCCURRED While <input checked="" type="checkbox"/> at work Not While <input type="checkbox"/> at work</p> <p>20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <u>S. Div. St. Ext. Rural - Salisbury (100.) Md.</u></p> <p>20f. (City or town) _____ (County) _____ (State) _____</p>		<p>21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from: Natural causes <input type="checkbox"/> Accident <input checked="" type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/></p> <p>CHIEF MEDICAL EXAMINER <input type="checkbox"/></p> <p>ASSISTANT MEDICAL EXAMINER <input type="checkbox"/></p> <p>DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/></p> <p>DATE SIGNED <u>Nov. 21 / 1960</u></p>	
<p>22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u></p> <p>22b. DATE THEREOF <u>Nov. 22, 1960</u></p> <p>22c. NAME OF CEMETERY OR CREMATORY <u>Pencons Cemetery</u></p> <p>22d. LOCATION (City, town, or country) <u>Salisbury, Maryland</u></p>		<p>23. FUNERAL DIRECTOR <u>HULLAY & COMPANY</u> ADDRESS <u>SALISBURY, MARYLAND</u></p> <p>24a. REC'D BY REGISTRAR <u>NOV 22 '60</u></p> <p>24b. REGISTRAR'S SIGNATURE <u>Arthur S. Thomas</u></p>	

ACTUAL SIGNATURE

EXAMINER'S NAME (Type)

22a. BURIAL, CREMATION, REMOVAL (Specify)

22b. DATE THEREOF

22c. NAME OF CEMETERY OR CREMATORY

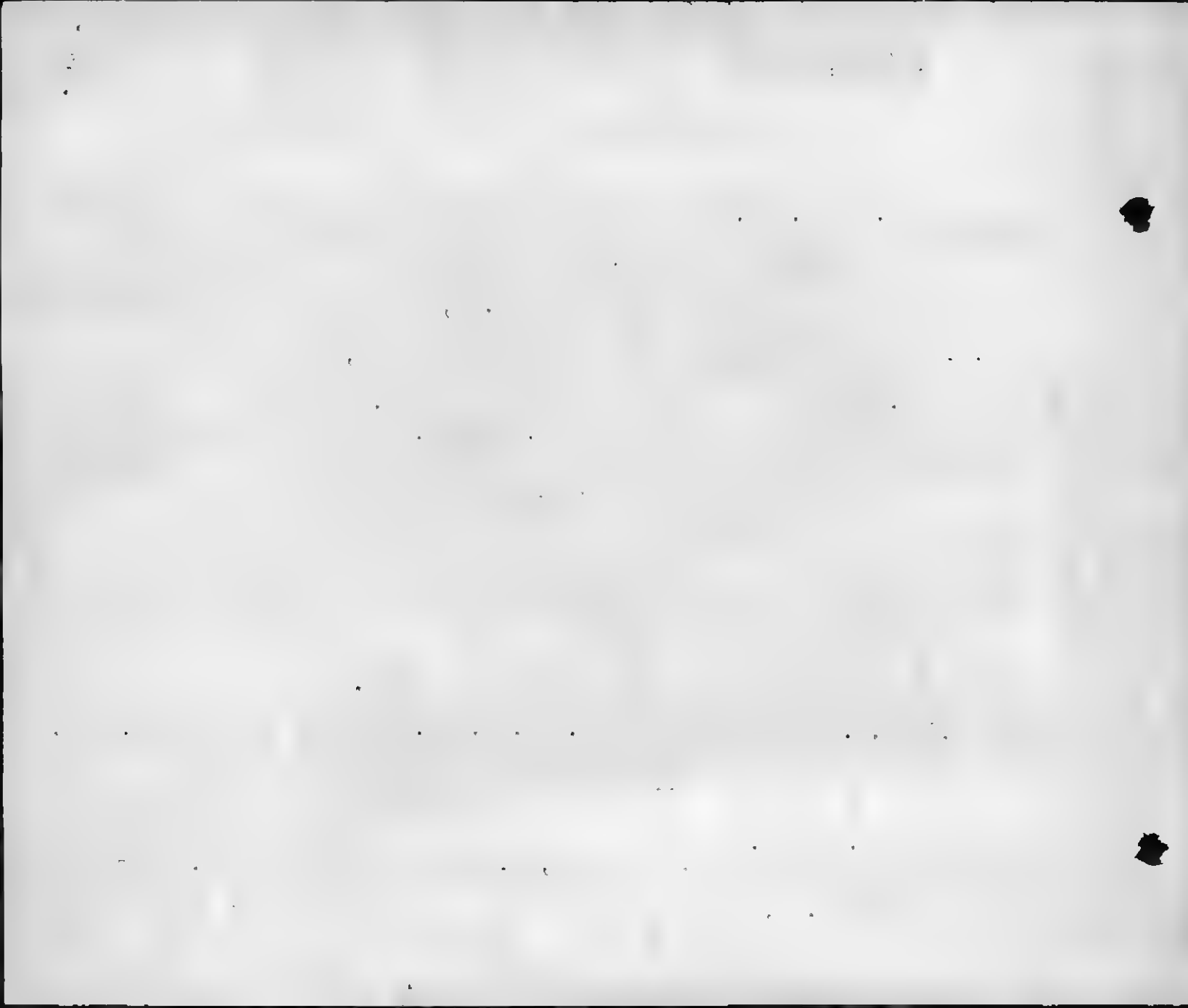
22d. LOCATION (City, town, or country)

23. FUNERAL DIRECTOR

ADDRESS

24a. REC'D BY REGISTRAR

24b. REGISTRAR'S SIGNATURE



1

INSTRUCTIONS

1 **TO ATTENDING PHYSICIAN OR HOSPITAL:** The law requires that the death certificate be executed within 24 hours after death. The bottom copy may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: The law requires that the death certificate be filed with the registrar within 72 hours after death. After this certificate has been executed by the attending physician and completely filled in by the funeral director, the third copy of this death certificate assembly should be detached for use as a burial transit permit.

VS AISC 1-55 10M

MARYLAND STATE DEPARTMENT OF HEALTH-BALTIMORE, 18

13223 CERTIFICATE OF DEATH

13172

Reg. Dist. No...

1. PLACE OF DEATH				2. USUAL RESIDENCE (HOME) OF DECEASED			
COUNTY <u>Wicomico</u>		MARYLAND		STATE <u>Maryland</u>		COUNTY <u>Wicomico</u>	
CITY (If outside corporate limits, write RURAL and give nearest town) TOWN <u>rural Mariela</u>		LENGTH OF STAY (In this place) <u>4 days</u>		CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN <u>Sharptown</u>			
HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>Maple Shade Nursing Home</u>				STREET ADDRESS <u>1 Main & Mariela road</u>			
3. NAME OF DECEASED (Type or Print) <u>HAZEL Phillips</u> (First) <u>LOWE</u> (Middle) (Last)				4. DATE OF DEATH <u>Nov. 24</u> 19 <u>60</u> (Month) (Day) (Year)			
5. SEX <u>female</u>	6. COLOR OR RACE <u>white</u>	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) <u>married</u>	8. DATE OF BIRTH <u>11, 1922</u>	9. AGE last birthday <u>5</u> yrs.	IF UNDER 1 YEAR Months Days		IF UNDER 24 HRS. Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Textile Operator</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>101st</u>		11. BIRTHPLACE (State or foreign country) <u></u>		12. CITIZEN OF WHAT COUNTRY? <u></u>	
13. FATHER'S NAME <u>Holland Smith</u>				14. MOTHER'S MAIDEN NAME <u>Virgie Phillis</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unk.) <u>1</u>		16. SOCIAL SECURITY NO. <u>216-3-5005</u>		17. INFORMANT & ADDRESS <u>Ervin Lowe, Sharptown, Md.</u>			
18. MEDICAL CERTIFICATION				INTERVAL BETWEEN ONSET AND DEATH			
18a. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH				<u>2 1/2 years</u>			
IMMEDIATE CAUSE (A) <u>4 cc carcinoma Breast</u>							
ANTECEDENT CAUSE(S) DUE TO							
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE							
STATING UNDERLYING CAUSE LAST. DUE TO							
18b. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.							
19a. DATE OF OPERATION		19b. MAJOR FINDINGS OF OPERATION		20. AUTOPSY?		YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.)		21c. WHERE DID INJURY OCCUR? (City or town) (County) (State)			
21d. TIME OF INJURY (Month) (Day) (Year) (Hour) M.		21e. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		21f. HOW DID INJURY OCCUR?			
22. I hereby certify that I attended the deceased from <u>11/24</u> , 19 <u>58</u> , to <u>Nov 24</u> , 19 <u>60</u> , that I last saw the deceased alive on <u>Nov 24</u> , 19 <u>60</u> , and that death occurred at <u>11:30 AM</u> , from the causes and on the date stated above.							
SIGNATURE <u>F. S. I. 11</u>				ADDRESS (Street, city, town, state) <u>145 E. Phillips M.D. Sharptown Md.</u>		DATE SIGNED <u>11/26/60</u>	
23. BURIAL, CREMATION, REMOVAL (SPECIFY) <u>burial</u>	DATE THEREOF <u>11-27-60</u>	NAME OF CEMETERY OR CREMATORY <u>Firemens</u>		LOCATION (City, town, or county) <u>Sharptown</u>		(State) <u></u>	
24. REC'D BY REGISTRAR <u>NOV 28 '60</u>	REGISTRAR'S SIGNATURE <u>Arthur S. Kraus</u>		25. FUNERAL DIRECTOR'S SIGNATURE <u>101st</u>		ADDRESS <u>Sharptown, Md.</u>		



TO HOSPITAL ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 1 hour after death. Page 4 may be used by the hospital or attending physician.

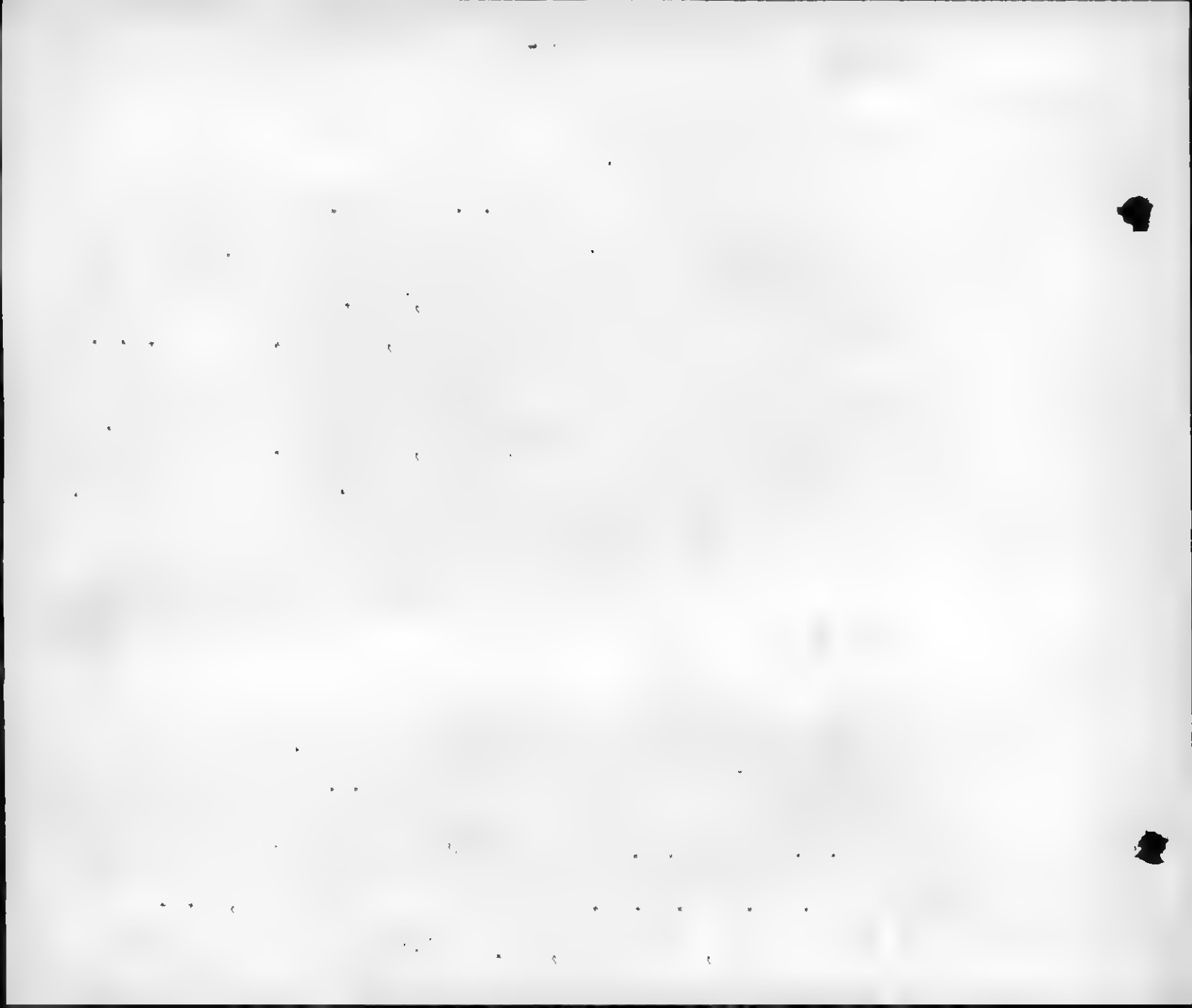
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Board of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND
CERTIFICATE OF DEATH

13192

13173

1 PLACE OF DEATH a. COUNTY Wicomico MARYLAND		2 USUAL RESIDENCE (Where deceased lived If institution: Residence before admission) a. STATE Virginia b. COUNTY ✓	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Salisbury		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Sterling	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Deer's Head Hospital		d. STREET ADDRESS P.O. Box #12.	
3. NAME OF Frances Eleanor McGurdy (Type or print) First Middle Last		4. DATE OF DEATH Month Nov. Day 28 Year 1960	
5 SEX Female	6 COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH April 23, 1872.
9 AGE (In years last birthday) 88 yrs		IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Retired		10b. KIND OF BUSINESS OR INDUSTRY Unk	
11 BIRTHPLACE (State or foreign country) Lawrence, Kansas.		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13 FATHER'S NAME Jesse Mc Curdy		14 MOTHER'S MAIDEN NAME Emily Anderson	
15 WAS DECEASED EVER IN U. S. ARMED FORCES? (If yes, give war or dates of service)		16. SOCIAL SECURITY NO.	
17 INFORMANT Records Of Deers Head State Hospt. Salisbury, Maryland.		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Hypostatic congestion of the lungs 420.0 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last (b) Arteriosclerotic heart disease DUE TO (c) Arteriosclerosis, generalized			INTERVAL BETWEEN ONSET AND DEATH 72 hrs. Years Years
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) Parkinsonism			19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18) N/A	
20c. TIME OF INJURY Month, Day, Year Hour o m. N/A 19 19		20d. INJURY OCCURRED White of work <input type="checkbox"/> Not while of work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office, bldg., etc.) N/A		20f. (City or town) (County) (State) N/A	
21 I certify that (I) (this hospital) attended the deceased from July 23 19 52 , to Nov. 28 19 60 , that (I) (we) last saw the deceased alive on Nov. 28 19 60 , and that death occurred at 12:45 P.M. from the causes and on the date stated above			
22a. SIGNATURE L. V. Maldve, M. D.		22b. DATE SIGNED 11/28/60	
22c. PHYSICIAN'S NAME (Type)		22d. ADDRESS Deer's Head Hospital; Salisbury, Md	
23a. BURIAL, CREMATION, REMOVAL (State)		23b. DATE THEREOF Nov. 30. 1960.	
23c. NAME OF CEMETERY OR CREMATORY J. Wm. Lees Sons		23d. LOCATION (City, town, or county) (State) Washington, D.C.	
24. FUNERAL DIRECTOR'S SIGNATURE Holloway & Company, Salisbury, Md.		25a. REC'D BY REGISTRAR DATE DEC 1 '60	
25b. REGISTRAR'S SIGNATURE C. L. G. Frank			



MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND
CERTIFICATE OF DEATH

13193

14502

1. PLACE OF DEATH a. COUNTY Wicomico MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution, residence before admission) a. STATE Maryland b. COUNTY Dorchester			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Salisbury				c. LENGTH OF STAY IN 1b 120 days		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Fishing Creek, Maryland.	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Deer's Head State Hospital				d. STREET ADDRESS None		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Middle Last Nannie Raye McGlaughlin				4. DATE OF DEATH Month Day Year Nov. 29 1960			
5. SEX Female	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 5/20/1879		9. AGE (In years last birthday) 81	10. IF UNDER 1 YEAR IF UNDER 24 HRS Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife		10b. KIND OF BUSINESS OR INDUSTRY Housewife		11. BIRTHPLACE (State or foreign country) Maryland		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME J. TOLLEY				14. MOTHER'S M A D E N NAME MARY CASKEY			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No		16. SOCIAL SECURITY NO No		17. INFORMANT DEER'S HEAD STATE HOSP. Address			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: 491X IMMEDIATE CAUSE (a) Bronchopneumonia DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) Arteriosclerosis, generalized							INTERVAL BETWEEN ONSET AND DEATH 3 days
20a. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) <input type="checkbox"/>				20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18)			
20c. TIME OF INJURY Hour a.m. p.m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from Aug. 1, 1960 to Nov. 29, 1960 , that (I) (we) last saw the deceased alive on Nov. 29, 1960 , and that death occurred at 1:45 P.M. from the causes and on the date stated above.							
22a. SIGNATURE <i>L. V. Maldve</i>				M.D. ATTENDING PHYS <input type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS <input checked="" type="checkbox"/>		22b. DATE SIGNED 11/29/60	
22c. PHYSICIAN'S NAME (Type) L. V. Maldve, M. D.				22d. ADDRESS Deer's Head Hospital; Salisbury, Md.			
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE THEREOF 12/2/1960		23c. NAME OF CEMETERY OR CREMATORY Dorchester Memorial Park		23d. LOCATION (City, town or county) (State) Cambridge, Maryland	
24. FUNERAL DIRECTOR'S SIGNATURE Le Compte Funeral Service, Cambridge, Maryland.				25a. REC'D BY REGISTRAR DEC 9 '60		25b. REGISTRAR'S SIGNATURE <i>Arthur L. Kneib</i>	

40

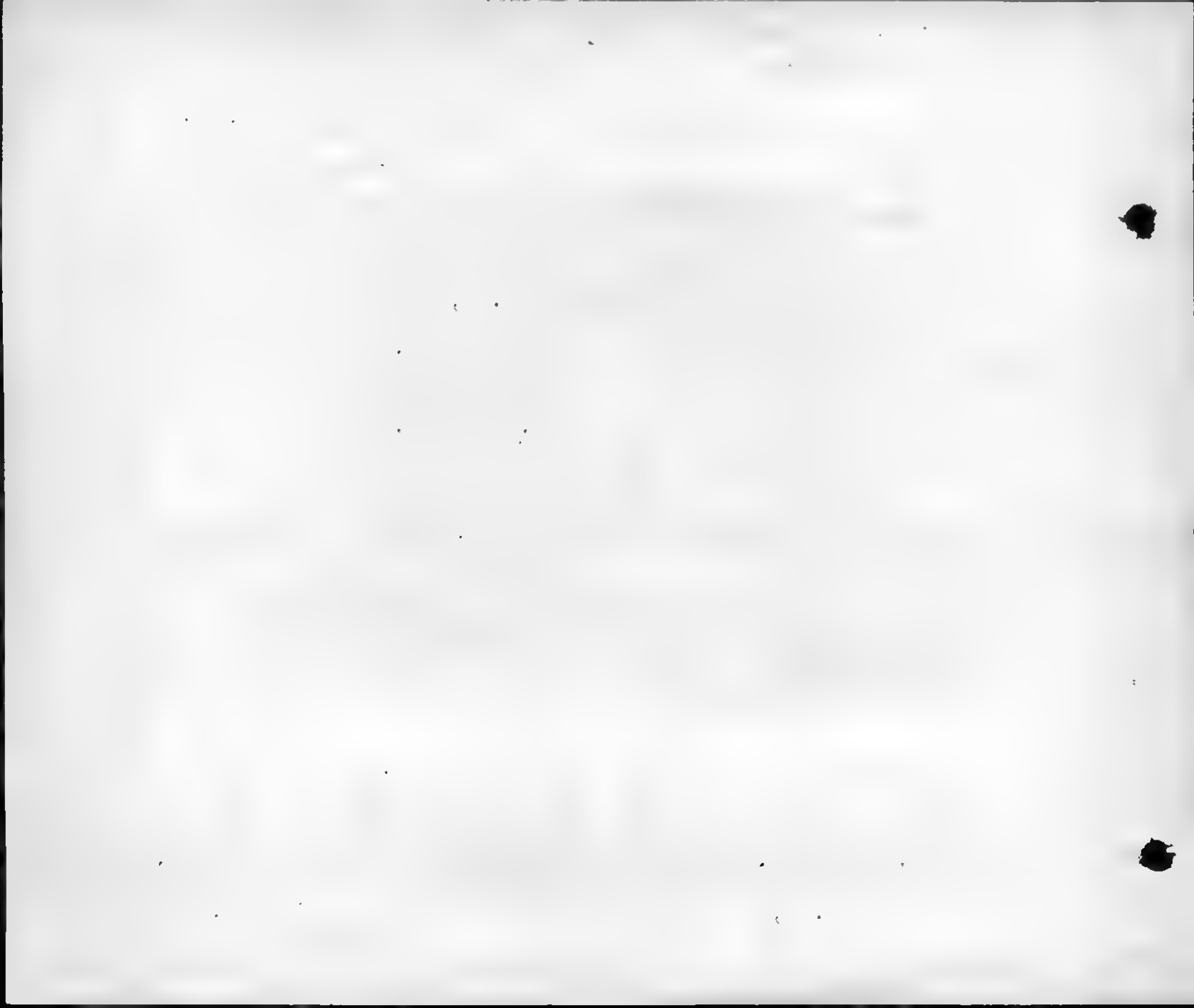
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1. The first step is to identify the problem or question that needs to be answered. This involves understanding the context and the specific requirements of the task.

[illegible]

13194
MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND
CERTIFICATE OF DEATH
13174

1 PLACE OF DEATH a. COUNTY <u>Wicomico</u> MARYLAND				2 USUAL RESIDENCE (Where deceased lived If institution Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>S. Anne</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Salisbury</u>				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Salisbury</u>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Wicomico General Hospital</u>				d. STREET ADDRESS <u>20 Brown St.</u>			
3 NAME OF DECEASED (Type or print) First Middle Last <u>Dorcas</u> <u>Henry</u> <u>Moore</u>				4. DATE OF DEATH Month Day Year <u>November</u> <u>11</u> <u>1960</u>			
5 SEX <u>Male</u>	6 COLOR OR RACE <u>White</u>	7 MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>Aug. 26, 1890</u>		9 AGE (In years last birthday) <u>70</u> yrs	IF UNDER 1 YEAR: Months Days Hours Min	
10a USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Office Manager-Sand & Gravel Co.</u>			10b KIND OF BUSINESS OR INDUSTRY <u>Houston, Delaware</u>		11. BIRTHPLACE (State or foreign country) <u>U S A</u>		
13. FATHER'S NAME <u>Levin Henry Moore</u>				14. MOTHER'S MAIDEN NAME <u>Tempa Gordy</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>No</u>		16. SOCIAL SECURITY NO. <u></u>		17. INFORMANT <u>Mrs. Mattie J. Moore (Wife)</u> Address <u>830 Brown St Salisbury, Maryland</u>			
18 CAUSE OF DEATH {Enter only one cause per line for (a), (b), and (c)} PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <u>ACUTE COR PULMONALE</u> <u>441X</u> DUE TO <u>ASPIRATION PNEUMONIA + PULMONARY EMPHYSEMA</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) DUE TO (c)						INTERVAL BETWEEN ONSET AND DEATH <u>5 DAYS</u>	
PART II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>Ch R. Cholecystitis + Ch. Icterus - Cholecystectomy</u>							
20a ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18) <u>N/A</u>					
20c. TIME OF INJURY Month, Day, Year Hour a. m. <u>N/A</u> 19 <u>60</u> p. m. <u>N/A</u>		20d INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg etc.) <u>N/A</u>		20f (City or town) <u>N/A</u> (County) (State)	
21 I certify that (I) (this hospital) attended the deceased from <u>Nov 4</u> 19 <u>60</u> to <u>Nov 11</u> 19 <u>60</u> , that (I) (we) last saw the deceased alive on <u>Nov 10</u> 19 <u>60</u> , and that death occurred at <u>12 M.</u> from the causes and on the date stated above.							
22a SIGNATURE <u>William B. Long</u> M.D.				ATTENDING PHYS <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS <input type="checkbox"/>		22b. DATE SIGNED <u>Nov 11, 1960</u>	
22c PHYSICIAN'S NAME (Type) <u>Dr. William B. Long</u>				22d. ADDRESS <u>Medical Center Salisbury, Maryland</u>			
23a BURIAL CREMATION, REMOVAL (Specify) <u>Burial</u>		23b DATE THEREOF <u>Nov. 14, 1960</u>		23c NAME OF CEMETERY OR CREMATORY <u>Wicomico Memorial Park Salisbury, Maryland</u>		23d LOCATION (City, town, or county) (State)	
24 FUNERAL DIRECTOR'S SIGNATURE <u>HOLLIS Y & COMPANY</u> ADDRESS <u>SALISBURY MARYLAND</u>				25a REC'D BY REG STRAR <u>NOV 16 '60</u> DATE		25b. REGISTRAR'S SIGNATURE <u>Arthur S. Kraus</u>	



1
FOR STATE
HEALTH DEPT.

MARYLAND STATE DEPARTMENT OF HEALTH

Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

1319 MEDICAL EXAMINER'S CERTIFICATE OF DEATH

13175

Item 9 Film G277 12-31-60 et

1. PLACE OF DEATH
a. COUNTY

Wicomico

MARYLAND

b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)

Salisbury

c. LENGTH OF STAY IN 1b

d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address)

715 Moore St.

2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission)

a. STATE

Maryland

b. COUNTY

Wicomico

c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)

Salisbury

d. STREET ADDRESS

715 Moore St.

e. IS RESIDENCE ON A FARM?
YES ☐ NO ☒

3. NAME OF DECEASED
(Type or print)

Isadore

Morris

4. DATE OF DEATH

11-28-60

19

5. SEX

M

C

6. COLOR OR RACE

7. MARRIED ☐ NEVER MARRIED ☐

8. DATE OF BIRTH

Sept 15, 1900

9. AGE (In years last birthday)

60/39 yrs

IF UNDER 1 YEAR

IF UNDER 24 HRS

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)

Laborer

10b. KIND OF BUSINESS OR INDUSTRY

none

11. BIRTHPLACE (State or foreign country)

Wicomico Co

12. CITIZEN OF WHAT COUNTRY?

USA

13. FATHER'S NAME

Etta Morris

14. MOTHER'S MAIDEN NAME

??

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give year or dates of service)

no

16. SOCIAL SECURITY NO.

218-05-8970

17. INFORMANT

Ruth Haggblom

Address

Salisbury Md

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]

PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a)

443X

DUE TO

Cerebral hemorrhage

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.

(b)

Hypertensive cardio-vascular disease

Years

DUE TO

(c)

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I

19. WAS AUTOPSY PERFORMED?
YES ☐ NO ☒

20a. EXTERNAL CAUSE WAS PRIMARY ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH.

20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)

20c. TIME OF INJURY
Hour a.m.
p.m.

Month, Day, Year
19

20d. INJURY OCCURRED
While at work ☐ Not While at work ☐

20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)

20f. (City or town)

(County)

(State)

21. I certify that I took charge of the remains described above, held an Autopsy ☐ Inspection ☒ Inquiry ☒ and in my opinion death resulted from: Natural causes ☒ Accident ☐ Suicide ☐ Homicide ☐ Undetermined manner ☐

ACTUAL SIGNATURE

Earl L. Royer

M.D.

CHIEF MEDICAL EXAMINER ☐

ASSISTANT MEDICAL EXAMINER ☐

DEPUTY MEDICAL EXAMINER ☐

DATE SIGNED

12-1-60

EXAMINER'S NAME (Type)

Earl L. Royer, M.D.

407 Camden Ave.

Salisbury, Md.

22a. BURIAL, CREMATION, REMOVAL (Specify)

Burial

22b. DATE THEREOF

12-3-60

22c. NAME OF CEMETERY OR CREMATORY

Green Acres Cem

22d. LOCATION (City, town, or country)

Salisbury Md

(State)

23. FUNERAL DIRECTOR

ADDRESS

Old Sunnyside Home Salisbury Md

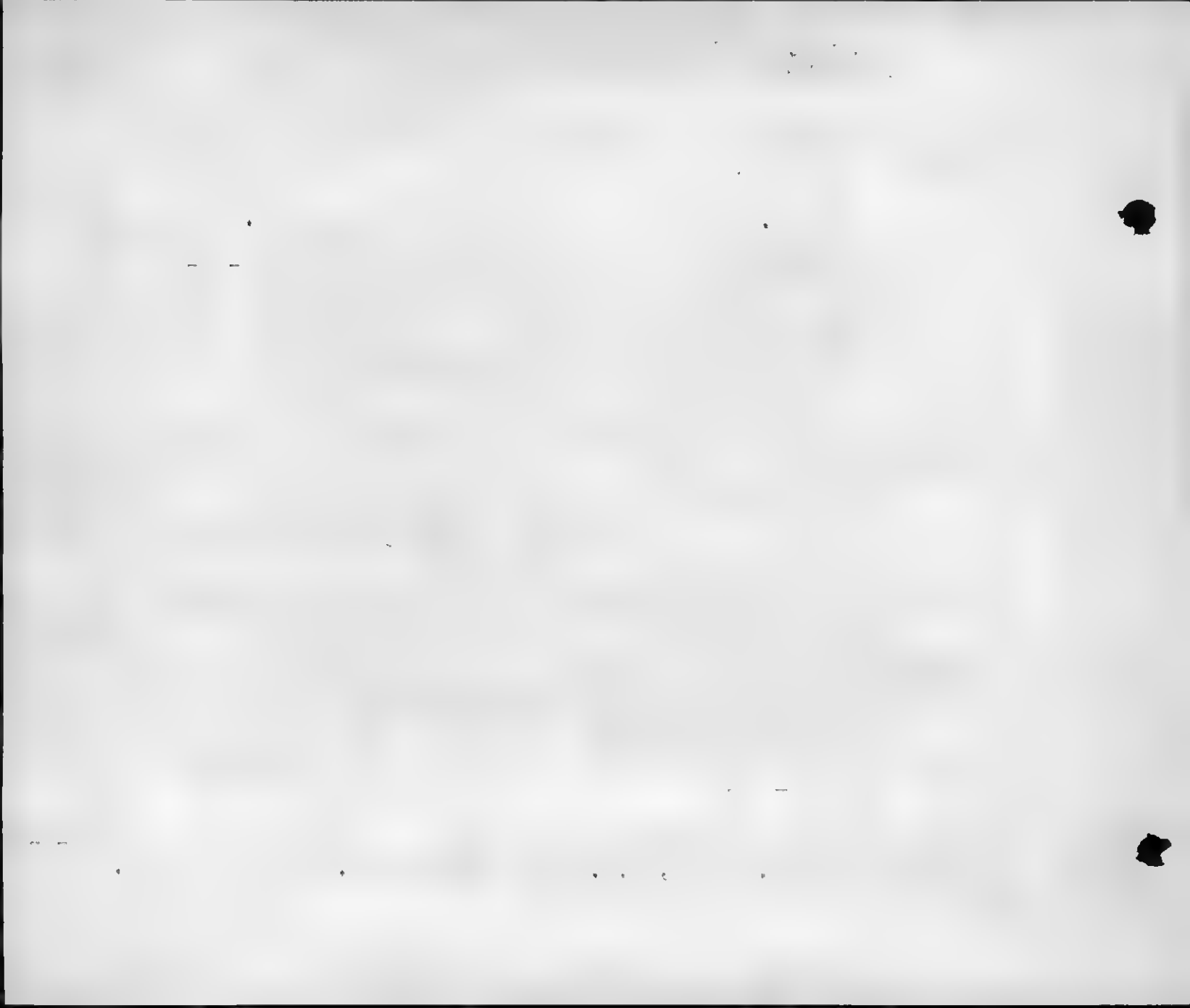
24a. REC'D BY REGISTRAR

24b. REGISTRAR'S SIGNATURE

DATE DEC 6 '60

Carlton L. Hanna

TO MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If an autopsy is necessary, please execute the certificate, writing the word "pending" in pencil in item 18. Give page 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM-3. Page 5 may be retained for your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. Fill page 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Board of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
15M 9/59

13196

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND
CERTIFICATE OF DEATH

13176

1. PLACE OF DEATH a. COUNTY Wicomico MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Somerset	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Salisbury		c. LENGTH OF STAY IN 1b 140 days	
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Eden, Maryland		d. STREET ADDRESS Rt. 1, Box 11	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Deer's Head State Hospital		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Mary Middle Elizabeth Last Nairne		4. DATE OF DEATH Month November Day 24 , Year 1960	
5. SEX Female	6. COLOR OR RACE Negro	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH Oct. 14, 1923
9. AGE (In years, last birthday) 37 yrs		10. IF UNDER 1 YEAR Months 37 Days 19	11. IF UNDER 24 HRS Hours 19 Min 19
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife		10b. KIND OF BUSINESS OR INDUSTRY --	
11. BIRTHPLACE (State or foreign country) Maryland		12. CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME Ulysses Cottman		14. MOTHER'S MAIDEN NAME Maggie Cannon	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No		16. SOCIAL SECURITY NO (If yes, give war or dates of service)	
17. INFORMANT Deer's Head State Hospital Records, Salisbury		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c)] PART I. DEATH WAS CAUSED BY: 332X IMMEDIATE CAUSE (a) Cerebral thrombosis DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) DUE TO (c) DUE TO		INTERVAL BETWEEN ONSET AND DEATH 2 days	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (If either, notify medical examiner) <input type="checkbox"/>		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. 19 p.m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from 7/7/60 , 19 , to 11/24 , 1960 , that (I) (we) last saw the deceased alive on Nov. 24th 1960 , and that death occurred at 7:PM , from the causes and on the date stated above.			
22a. SIGNATURE V. Juerman		22b. DATE 11/25/60	
22c. PHYSICIAN'S NAME (Type) V. Juerman, M.D.		22d. ADDRESS Deer's Head State Hospital, Salisbury, Md.	
23a. BURIAL CREMATION, REMOVAL (Specify) REMOVAL		23b. DATE THEREOF 11/27/60	
23c. NAME OF CEMETERY OR CREMATORY St Mary		23d. LOCATION (City, town, or county) (State) West Post Office, Maryland	
24. FUNERAL DIRECTOR'S SIGNATURE William H. James Jr., Princess Anne, Md		25a. RECORD BY REGISTRAR NOV 28 '60	
25b. REGISTRAR'S SIGNATURE Arthur L. H.			



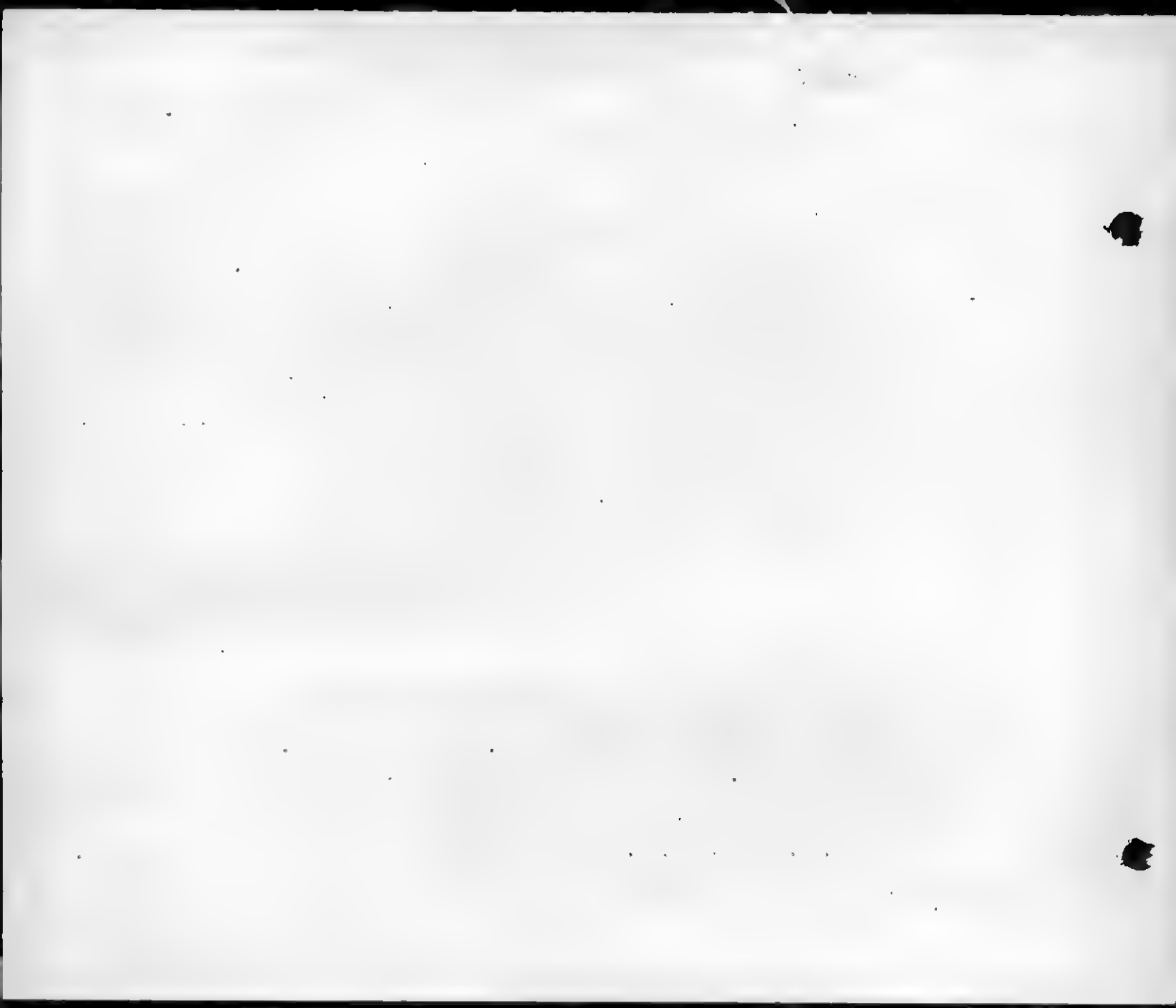
MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND
CERTIFICATE OF DEATH

13177

13197

1 PLACE OF DEATH a. COUNTY Wicomico MARYLAND		2 USUAL RESIDENCE (Where deceased lived If institution: Residence before admission) a. STATE Maryland b. COUNTY Caroline ✓	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Salisbury		c. LENGTH OF STAY IN lb 2205 days	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Deer's Head State Hospital		d. STREET ADDRESS Preston	
3 NAME OF DECEASED (Type or print) First Lulu Middle Newcomer Last Newcomer		4. DATE OF DEATH Month Nov. Day 16 Year 1960	
5. SEX Female	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 1869
9. AGE (In years last birthday) 91 yrs.		10. IF UNDER 1 YEAR Months 9 Days 16 Hours 16 Min 16	
10a. USUAL OCCUPATION (Give kind of work done during most of working life. If retired) Housewife		10b. KIND OF BUSINESS OR INDUSTRY Housewife	
11. BIRTHPLACE (State or foreign country) Maryland		12. CITIZEN OF WHAT COUNTRY? U.S.	
13. FATHER'S NAME William Neal		14. MOTHER'S MAIDEN NAME unknown	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) No		16. SOCIAL SECURITY NO. —	
17. INFORMANT M. Cecelia Newman		Address Easton Md.	
18 CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Arteriosclerotic heart disease DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) Arteriosclerosis, general DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) Acute cholecystitis			INTERVAL BETWEEN ONSET AND DEATH Yrs Yrs
19 WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. 19 p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21 I certify that (I) (this hospital) attended the deceased from Nov. 3 1960 , to Nov. 16 1960 , that (I) (we) last saw the deceased alive on Nov. 15 1960 , and that death occurred at 3A.M. from the causes and on the date stated above			
22a. SIGNATURE L. V. Maldve		22b. DATE SIGNED 11/16/60	
22c. PHYSICIAN'S NAME (Type) L. V. Maldve, M. D.		22d. ADDRESS Deer's Head Hospital; Salisbury, Md.	
23a. BURIAL CREMATION OR REMOVAL (Specify) Burial		23b. DATE THEREOF Nov 18, 1960	
23c. NAME OF CEMETERY OR CREMATORY Spring Hill Cem		23d. DEATH ONLY (City, town, or county) (State) Easton Md.	
24. FUNERAL DIRECTOR'S SIGNATURE Marvin E. Newman & Son		ADDRESS Easton Md.	
25a. REC'D BY REGISTRAR DATE NOV 22 '60		25b. REGISTRAR'S SIGNATURE Charles S. Francis	

TO HOSPITAL: The low requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Board of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Board of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

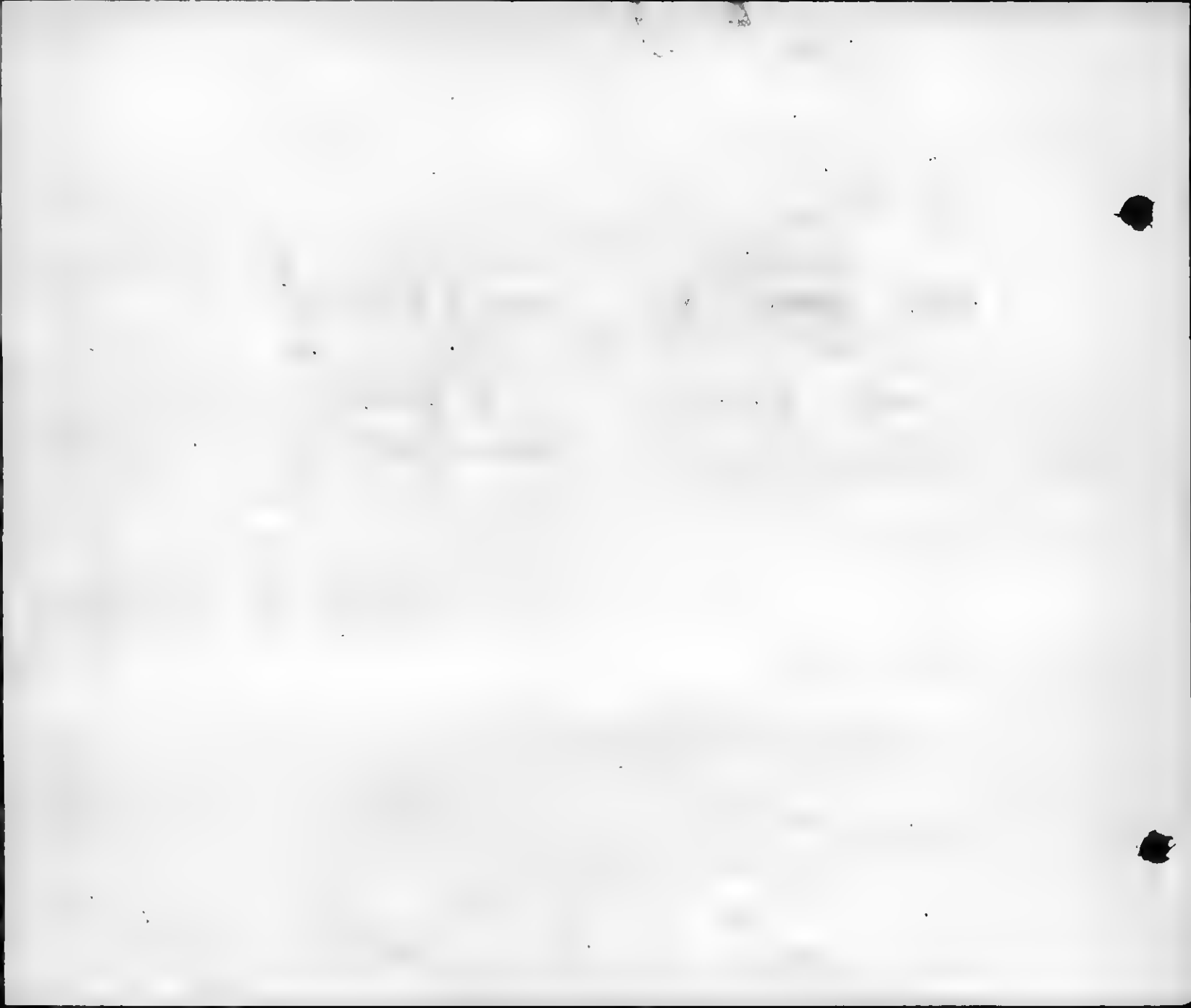
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13198

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND
CERTIFICATE OF DEATH

13178

1 PLACE OF DEATH a. COUNTY <u>Wicomico</u> MARYLAND		2 USUAL RESIDENCE (Where deceased lived If institution, Residence before admission) a STATE <u>Maryland</u> b COUNTY <u>Worcester</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Salisbury</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Pocomoke City</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Age Home</u>		d. STREET ADDRESS <u>224 X 2</u>	
3 NAME OF DECEASED (Type or print) First <u>George</u> Middle <u>Parson</u> Last <u>Parson</u>		4. DATE OF DEATH Month <u>Nov.</u> Day <u>19</u> Year <u>1960</u>	
5 SEX <u>Male</u>	6 COLOR OR RACE <u>Negro</u>	7 MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8 DATE OF BIRTH <u>Oct. 19, 1893</u>
9a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Laborer</u>		9b. AGE (in years last birthday) <u>67</u> yrs	
10b. KIND OF BUSINESS OR INDUSTRY <u>YARD-Work</u>		11. BIRTHPLACE (State or foreign country) <u>Maryland</u>	
12 CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>			
13 FATHER'S NAME <u>Peter Parson</u>		14 MOTHER'S MAIDEN NAME <u>Elizabeth Cropper</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (If yes, give war or dates of service) <u>No</u>		16 SOCIAL SECURITY NO	
17 INFORMANT <u>Alice Soane</u> Address <u>Pocomoke City, Md.</u>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <u>Central Sclerosis</u> DUE TO (b) <u>Arterio Sclerosis</u> DUE TO (c) <u>Unk</u>		INTERVAL BETWEEN ONSET AND DEATH <u>Unk</u>	
PART II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>Keyphosis - Scoliosis - Spine</u>			
19 WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>			
20a ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18)	
20c TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19		20d INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work	
20e PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f (City or town) (County) (State)	
21 I certify that (I) (this hospital) attended the deceased from <u>Nov. 12, 1960</u> to <u>Nov. 19, 1960</u> that (I) (we) last saw the deceased alive on <u>Nov. 11, 1960</u> and that death occurred at <u>5 PM</u> , from the causes and on the date stated above			
22a SIGNATURE <u>G. Herbert Semble</u>		22b DATE <u>Nov. 21/60</u>	
22c PHYSICIAN'S NAME (Type) <u>G. Herbert Semble</u>		22d ADDRESS <u>Salisbury, Md.</u>	
23a BURIAL, CREMATION, REMOVAL (Specify)		23b DATE THEREOF	
<u>Burial</u>		<u>Nov. 27, 1960</u>	
23c NAME OF CEMETERY OR CREMATORY		23d LOCATION (City, town or county) (State)	
<u>Hall's Hill Cem.</u>		<u>Pocomoke City, Md.</u>	
24 FUNERAL DIRECTOR'S SIGNATURE <u>Edgar Whorton - New Church, Va.</u>		25a REC'D BY REGISTRAR DATE <u>NOV 23 '60</u>	
25b REGISTRAR'S SIGNATURE <u>Arthur L. Kline</u>			



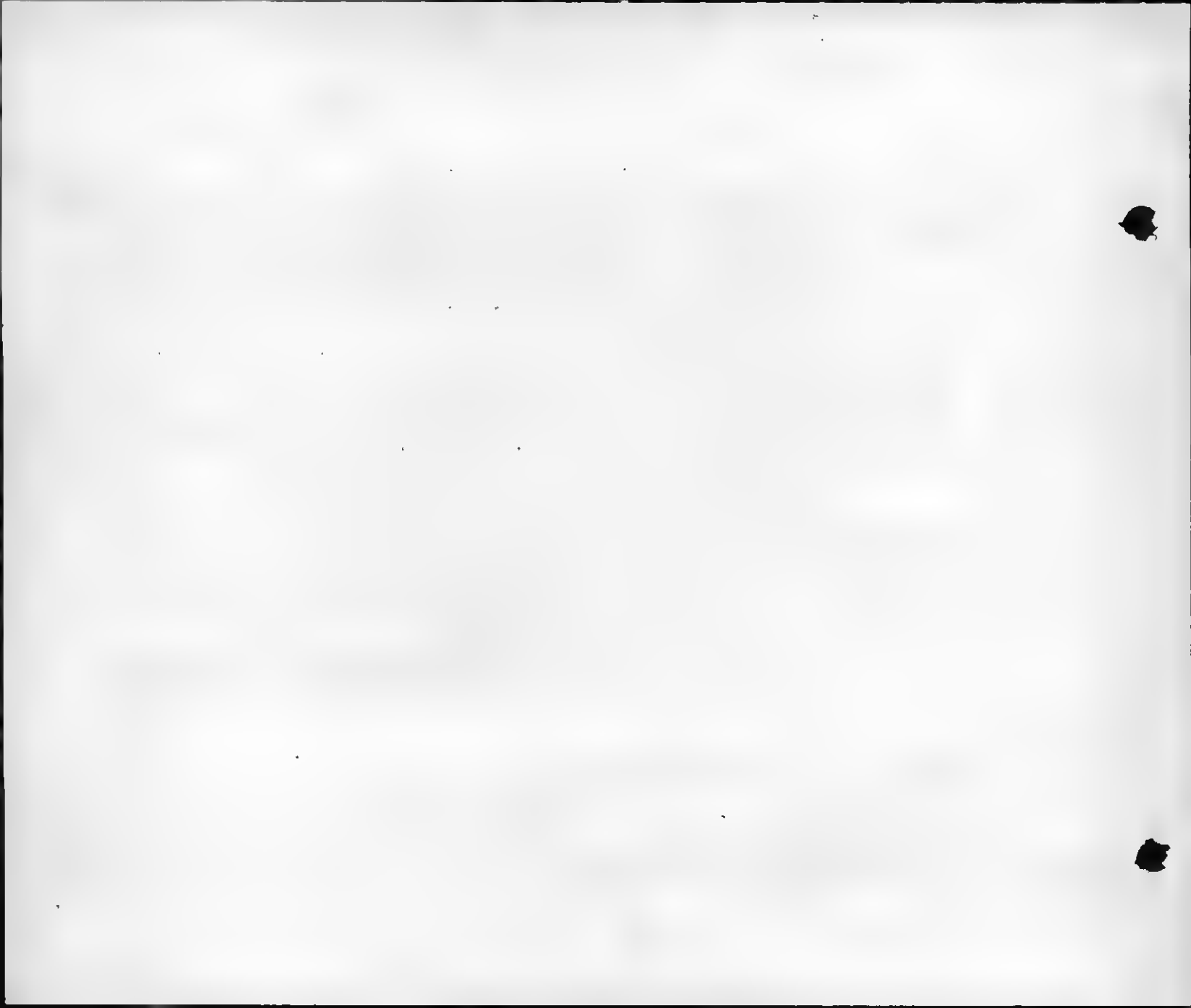
MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND
CERTIFICATE OF DEATH

13179

13224

1. PLACE OF DEATH a. COUNTY Wicomico				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Dorchester				
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Mardela Springs - Rural			c. LENGTH OF STAY IN 1b 3 yrs. 8mons.			c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Rhodesdale - Rural		
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Maple S hado Convalescent Home				d. STREET ADDRESS Eldorado		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		
3. NAME OF (Type or print) First Middle Last Annie Elizabeth Payne				4. DATE OF DEATH Month Day Year November 2 1960				
5. SEX Female		6. COLOR OR RACE White		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH Jan. 20, 1870		
9. AGE (In years last birthday) 90 yrs		10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housework		10b. KIND OF BUSINESS OR INDUSTRY Home		11. BIRTHPLACE (State or foreign country) Dorchester Co., Maryland		
12. CITIZEN OF WHAT COUNTRY? U.S.A.								
13. FATHER'S NAME John Corkran				14. MOTHER'S MAIDEN NAME Elizabeth Rhodes				
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) No		16. SOCIAL SECURITY NO None		17. INFORMANT Address Mrs. Russel W. Hallowell, Federalsburg, Md.				
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: 450.0 IMMEDIATE CAUSE (a) Due to Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Due to (c)							INTERVAL BETWEEN ONSET AND DEATH 15	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)								
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)				
20c. TIME OF INJURY Month Day Year Hour a. m. p. m. 19				20d. INJURY OCCURRED While <input type="checkbox"/> at work Not while <input type="checkbox"/> at work		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		
20f. (City or town) (County) (State)								
21. I certify that (I) (this hospital) attended the deceased from 1956 to 1960 that (I) (we) last saw the deceased alive on 12/1 19 and that death occurred at 8A M, from the causes and on the date stated above.								
22a. SIGNATURE Attending Physician				22b. DATE SIGNED NOV 9 '60				
22c. PHYSICIAN'S NAME (Type) J. J. Frampton				22d. ADDRESS Federalsburg, Md.				
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE THEREOF Nov. 4, 1960		23c. NAME OF CEMETERY OR CREMATORY Eldorado Cemetery		23d. LOCATION (City, town, or county) (State) Eldorado, Dorchester Co., Md.		
24. FUNERAL DIRECTOR'S SIGNATURE J. J. Frampton and Son, Federalsburg, Maryland				25a. REC'D BY REGISTRAR DATE NOV 9 '60		25b. REGISTRAR'S SIGNATURE Arthur L. Hines		

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
 TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Board of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.



8-24513180

CERTIFICATE OF DEATH

Reg. Dist. No.

13199

1. PLACE OF DEATH a. COUNTY <u>Wicomico</u> b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Salisbury</u> c. LENGTH OF STAY IN 1b <u>Life</u> d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Life</u>		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>MD</u> b. COUNTY <u>Wicomico</u> c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Salisbury, MD</u> d. STREET ADDRESS <u>805 W. Main St</u> e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) <u>Ella</u> First <u>Peters</u> Middle <u>Peters</u> Last <u>Peters</u>		4. DATE OF DEATH Month <u>11</u> Day <u>28</u> Year <u>1960</u>	
5. SEX <u>Female</u>	6. COLOR OR RACE <u>Cal</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>12-11-1869</u>
9. AGE (In years last birthday) <u>90</u> yrs.		10. IF UNDER 1 YEAR Months <u>0</u> Days <u>0</u> Hours <u>0</u> Min. <u>0</u>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life even if retired) <u>Domestic</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>none</u>	
11. BIRTHPLACE (State or foreign country) <u>Wicomico</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>Ed. Jeff. Binkard</u>		14. MOTHER'S MAIDEN NAME <u>Domine Smith</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>none</u>		16. SOCIAL SECURITY NO. <u>none</u>	
17. INFORMANT <u>Mary Carroll</u> Address <u>Salisbury, Md.</u>		18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Cardio-Vascular Accident</u> <u>443X</u> DUE TO (b) <u>Hypertensive Cardiovascular Disease</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (c) <u>Senile</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <u>19</u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input checked="" type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <u>Nov. 5, 1960</u> to <u>Nov. 23, 1960</u> that I last saw the deceased alive on <u>Nov. 19, 1960</u> , and that death occurred at <u>8:45</u> M, from the causes and on the date stated above.			
ACTUAL SIGNATURE <u>G. Herbert Sembly</u> M.D.		DATE SIGNED <u>Nov. 29, 60</u>	
PHYSICIAN'S NAME (Type) <u>G. Herbert Sembly</u>		ADDRESS (Street, city or town, state) <u>Salisbury, Md.</u>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>11-27-60</u>	
22c. NAME OF CEMETERY OR CREMATORY <u>Green Acres</u>		22d. LOCATION (City, town, or county) (State) <u>Salisbury, Md.</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>Boakes M. West</u>		ADDRESS	
24a. REC'D BY REGISTRAR DATE <u>DEC 6 '60</u>		24b. REGISTRAR'S SIGNATURE <u>Arthur S. Hines</u>	

TO HOSPITAL: ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filled with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.



may be signed by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled out, the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Board of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND

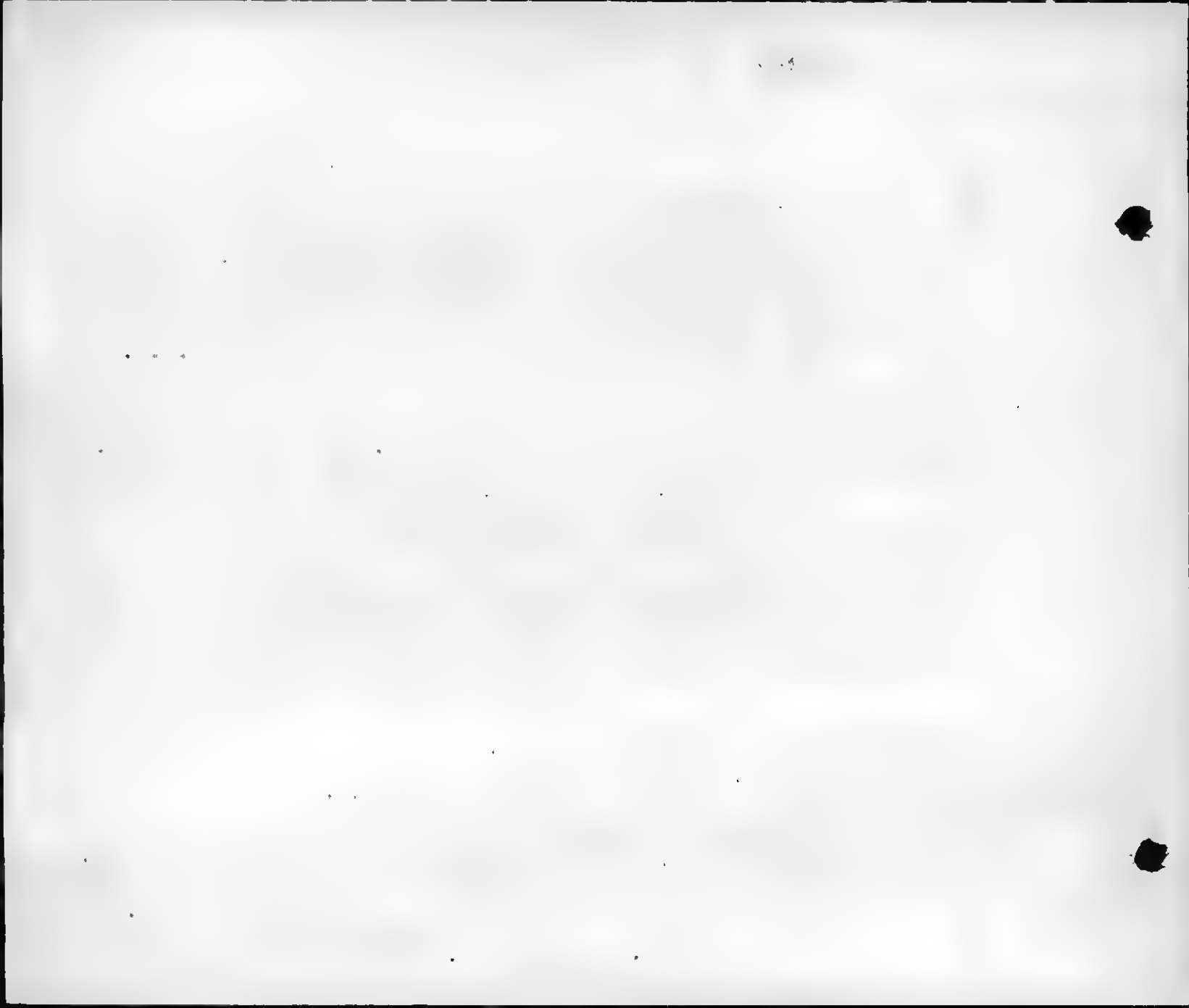
13200

CERTIFICATE OF DEATH

13181

Items 7, 8, 9, 11, 12, 13, 14, 15, 16, 17, 18, 19, 20, 21, 22, 23, 24, 25, 26, 27, 28, 29, 30, 31, 32, 33, 34, 35, 36, 37, 38, 39, 40, 41, 42, 43, 44, 45, 46, 47, 48, 49, 50, 51, 52, 53, 54, 55, 56, 57, 58, 59, 60, 61, 62, 63, 64, 65, 66, 67, 68, 69, 70, 71, 72, 73, 74, 75, 76, 77, 78, 79, 80, 81, 82, 83, 84, 85, 86, 87, 88, 89, 90, 91, 92, 93, 94, 95, 96, 97, 98, 99, 100, 101, 102, 103, 104, 105, 106, 107, 108, 109, 110, 111, 112, 113, 114, 115, 116, 117, 118, 119, 120, 121, 122, 123, 124, 125, 126, 127, 128, 129, 130, 131, 132, 133, 134, 135, 136, 137, 138, 139, 140, 141, 142, 143, 144, 145, 146, 147, 148, 149, 150, 151, 152, 153, 154, 155, 156, 157, 158, 159, 160, 161, 162, 163, 164, 165, 166, 167, 168, 169, 170, 171, 172, 173, 174, 175, 176, 177, 178, 179, 180, 181, 182, 183, 184, 185, 186, 187, 188, 189, 190, 191, 192, 193, 194, 195, 196, 197, 198, 199, 200, 201, 202, 203, 204, 205, 206, 207, 208, 209, 210, 211, 212, 213, 214, 215, 216, 217, 218, 219, 220, 221, 222, 223, 224, 225, 226, 227, 228, 229, 230, 231, 232, 233, 234, 235, 236, 237, 238, 239, 240, 241, 242, 243, 244, 245, 246, 247, 248, 249, 250, 251, 252, 253, 254, 255, 256, 257, 258, 259, 260, 261, 262, 263, 264, 265, 266, 267, 268, 269, 270, 271, 272, 273, 274, 275, 276, 277, 278, 279, 280, 281, 282, 283, 284, 285, 286, 287, 288, 289, 290, 291, 292, 293, 294, 295, 296, 297, 298, 299, 300, 301, 302, 303, 304, 305, 306, 307, 308, 309, 310, 311, 312, 313, 314, 315, 316, 317, 318, 319, 320, 321, 322, 323, 324, 325, 326, 327, 328, 329, 330, 331, 332, 333, 334, 335, 336, 337, 338, 339, 340, 341, 342, 343, 344, 345, 346, 347, 348, 349, 350, 351, 352, 353, 354, 355, 356, 357, 358, 359, 360, 361, 362, 363, 364, 365, 366, 367, 368, 369, 370, 371, 372, 373, 374, 375, 376, 377, 378, 379, 380, 381, 382, 383, 384, 385, 386, 387, 388, 389, 390, 391, 392, 393, 394, 395, 396, 397, 398, 399, 400, 401, 402, 403, 404, 405, 406, 407, 408, 409, 410, 411, 412, 413, 414, 415, 416, 417, 418, 419, 420, 421, 422, 423, 424, 425, 426, 427, 428, 429, 430, 431, 432, 433, 434, 435, 436, 437, 438, 439, 440, 441, 442, 443, 444, 445, 446, 447, 448, 449, 450, 451, 452, 453, 454, 455, 456, 457, 458, 459, 460, 461, 462, 463, 464, 465, 466, 467, 468, 469, 470, 471, 472, 473, 474, 475, 476, 477, 478, 479, 480, 481, 482, 483, 484, 485, 486, 487, 488, 489, 490, 491, 492, 493, 494, 495, 496, 497, 498, 499, 500, 501, 502, 503, 504, 505, 506, 507, 508, 509, 510, 511, 512, 513, 514, 515, 516, 517, 518, 519, 520, 521, 522, 523, 524, 525, 526, 527, 528, 529, 530, 531, 532, 533, 534, 535, 536, 537, 538, 539, 540, 541, 542, 543, 544, 545, 546, 547, 548, 549, 550, 551, 552, 553, 554, 555, 556, 557, 558, 559, 560, 561, 562, 563, 564, 565, 566, 567, 568, 569, 570, 571, 572, 573, 574, 575, 576, 577, 578, 579, 580, 581, 582, 583, 584, 585, 586, 587, 588, 589, 590, 591, 592, 593, 594, 595, 596, 597, 598, 599, 600, 601, 602, 603, 604, 605, 606, 607, 608, 609, 610, 611, 612, 613, 614, 615, 616, 617, 618, 619, 620, 621, 622, 623, 624, 625, 626, 627, 628, 629, 630, 631, 632, 633, 634, 635, 636, 637, 638, 639, 640, 641, 642, 643, 644, 645, 646, 647, 648, 649, 650, 651, 652, 653, 654, 655, 656, 657, 658, 659, 660, 661, 662, 663, 664, 665, 666, 667, 668, 669, 670, 671, 672, 673, 674, 675, 676, 677, 678, 679, 680, 681, 682, 683, 684, 685, 686, 687, 688, 689, 690, 691, 692, 693, 694, 695, 696, 697, 698, 699, 700, 701, 702, 703, 704, 705, 706, 707, 708, 709, 710, 711, 712, 713, 714, 715, 716, 717, 718, 719, 720, 721, 722, 723, 724, 725, 726, 727, 728, 729, 730, 731, 732, 733, 734, 735, 736, 737, 738, 739, 740, 741, 742, 743, 744, 745, 746, 747, 748, 749, 750, 751, 752, 753, 754, 755, 756, 757, 758, 759, 760, 761, 762, 763, 764, 765, 766, 767, 768, 769, 770, 771, 772, 773, 774, 775, 776, 777, 778, 779, 780, 781, 782, 783, 784, 785, 786, 787, 788, 789, 790, 791, 792, 793, 794, 795, 796, 797, 798, 799, 800, 801, 802, 803, 804, 805, 806, 807, 808, 809, 810, 811, 812, 813, 814, 815, 816, 817, 818, 819, 820, 821, 822, 823, 824, 825, 826, 827, 828, 829, 830, 831, 832, 833, 834, 835, 836, 837, 838, 839, 840, 841, 842, 843, 844, 845, 846, 847, 848, 849, 850, 851, 852, 853, 854, 855, 856, 857, 858, 859, 860, 861, 862, 863, 864, 865, 866, 867, 868, 869, 870, 871, 872, 873, 874, 875, 876, 877, 878, 879, 880, 881, 882, 883, 884, 885, 886, 887, 888, 889, 890, 891, 892, 893, 894, 895, 896, 897, 898, 899, 900, 901, 902, 903, 904, 905, 906, 907, 908, 909, 910, 911, 912, 913, 914, 915, 916, 917, 918, 919, 920, 921, 922, 923, 924, 925, 926, 927, 928, 929, 930, 931, 932, 933, 934, 935, 936, 937, 938, 939, 940, 941, 942, 943, 944, 945, 946, 947, 948, 949, 950, 951, 952, 953, 954, 955, 956, 957, 958, 959, 960, 961, 962, 963, 964, 965, 966, 967, 968, 969, 970, 971, 972, 973, 974, 975, 976, 977, 978, 979, 980, 981, 982, 983, 984, 985, 986, 987, 988, 989, 990, 991, 992, 993, 994, 995, 996, 997, 998, 999, 1000

1. PLACE OF DEATH a. COUNTY Wicomico MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Somerset ✓	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Salisbury		c. LENGTH OF STAY IN lb 405 days	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Deer's Head State Hospital		e. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Princess Anne,	
3. NAME OF DECEASED (Type or print) First George Middle Norman Last Pusey		4. DATE OF DEATH Month Nov. Day 14 Year 1960	
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH Oct. 25, 1887
9. AGE (In years last birthday) 83 yrs		10. IF UNDER 1 YEAR Months 2 Days 10 Hours 10 Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) retired farmer		10b. KIND OF BUSINESS OR INDUSTRY former	
11. BIRTHPLACE (State or foreign country) Maryland		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME George Pusey		14. MOTHER'S MAIDEN NAME Margaret brown	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO. Mrs William H. Raurk Westover, Id.	
17. INFORMANT Mrs William H. Raurk Westover, Id.		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Cerebral thrombosis DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last (b) Generalized arteriosclerosis DUE TO (c)			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) Diabetes mellitus			
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		INTERVAL BETWEEN ONSET AND DEATH 2 months	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. 19 p. m.		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from Oct. 6 1959 to Nov. 14 1960 , that (I) (we) last saw the deceased alive on Nov. 13, 1960 , and that death occurred at M. from the causes and on the date stated above.			
22a. SIGNATURE Lee L. Lawry		22b. DATE 12:15 A.M.	
22c. PHYSICIAN'S NAME (Type) Lee L. Lawry, M. D.		22d. ADDRESS Deer's Head Hospital; Salisbury, Md.	
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE THEREOF 11-16-1960	
23c. NAME OF CEMETERY OR CREMATORY Manokin Presbyterian		23d. LOCATION (City, town, or county) (State) Princess Anne, Md.	
24. FUNERAL DIRECTOR'S SIGNATURE Princess Anne, Md.		25a. REC'D BY REGISTRAR NOV 21 '60	
25b. REGISTRAR'S SIGNATURE Arthur S. Frank			



STATE OF MARYLAND
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND
CERTIFICATE OF DEATH

13182

13201

1. PLACE OF DEATH a. COUNTY Wicomico MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Wicomico			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Salisbury				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Salisbury			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION 139 Upton St				d. STREET ADDRESS 139 Upton St		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First SALLIE Middle JANE Last BUARK				4. DATE OF DEATH Month NOV. Day 5th Year 1960			
5. SEX Female	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH Aug. 27, 1886	9. AGE (In years last birthday) 74 yrs	IF UNDER 1 YEAR Months 2 Days 8	IF UNDER 24 HRS. Hours Min 	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) House Work at home		10b. KIND OF BUSINESS OR INDUSTRY None		11. BIRTHPLACE (State or foreign country) Sussex Co. Delaware		12. CITIZEN OF WHAT COUNTRY? U S A	
13. FATHER'S NAME Johanthan C. Timmons				14. MOTHER'S MAIDEN NAME Sarah F. Short			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No		16. SOCIAL SECURITY NO. INFORMANT		Address Mr. Charles W. Parker (Grandson) 719 Rogers Street - Salisbury, Maryland			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c)] PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) generalized carcinoma 174X DUE TO (b) carcinoma of uterus Conditions, if any, which gave rise to immediate cause (a), stating the <u>underlying</u> cause last. (c) 						INTERVAL BETWEEN ONSET AND DEATH Noted 1959	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) Diabetes mellitus							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) N/A					
20c. TIME OF INJURY Month. N/A Day. 19 Year 19 Hour a. m. p. m. 		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) N/A		20f. (City or town) N/A (County) (State) 	
21. I certify that (I) (this hospital) attended the deceased from October 8, 1960 to November 5, 1960 that (I) was last saw the deceased alive on November 4, 1960 , and that death occurred at 8:45 PM , from the causes and on the date stated above							
22a. SIGNATURE Dr. Robert T. Adkins				22b. DATE SIGNED Nov. 7, 1960			
22c. PHYSICIAN'S NAME (Type) Dr. Robert T. Adkins				22d. ADDRESS Fruitland, Maryland			
23a. BURIAL CREMATION, REMOVAL (Specify) Burial		23b. DATE THEREOF Nov. 8, 1960		23c. NAME OF CEMETERY OR CREMATORY Parsonsbury Cemetery		23d. LOCATION (City, town, or county) (State) Parsonsbury, Maryland	
24. FUNERAL DIRECTOR'S SIGNATURE F. L. W. & COMPANY				ADDRESS SALISBURY MARYLAND		25a. REC'D BY REGISTRAR DATE NOV 9 '60	
				25b. REGISTRAR'S SIGNATURE Arthur S. Kline			

TO HOSPITAL OR ATTENDING PHYSICIAN: This law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Board of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.



MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND

13183

13202 Item 2 Film 276 12-6-60 et

CERTIFICATE OF DEATH

1 PLACE OF DEATH a. COUNTY Wicomico MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Wicomico	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Salisbury		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Salisbury	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Peninsula General Hospital		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3 NAME OF DECEASED (Type or print) Elizabeth First Middle Last		d. STREET ADDRESS 719 Rose Street	
5 SEX FEMALE		6 COLOR OR RACE Colored	
7 MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8 DATE OF BIRTH February 18, 1941	
9 AGE (In years lost birthday) 19 yrs.		10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) None	
11. BIRTHPLACE (State or foreign country) Maryland		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13 FATHER'S NAME Isaac Sample		14 MOTHER'S MAIDEN NAME Elizabeth Finey	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) no		16 SOCIAL SECURITY NO. Elizabeth Finey 719 Rose St Salisbury Md	
17 INFORMANT Elizabeth Finey Address 719 Rose St Salisbury Md		18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) Dilatation of Rt Ventricle & atrium 4343 DUE TO Hydro pericardium Conditions, if any, which gave rise to immediate cause (c), stating the underlying cause last. Coronary changes - Trachea - bronchitis	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>	
20a ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 11/22/60		20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> of work of work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21 I certify that (I) (this hospital) attended the deceased from 11/22/60 , 19 11/22/60 , that (I) (we) last saw the deceased alive on 11/22/60 , and that death occurred at 7:45 M , from the causes and on the date stated above.			
22a. SIGNATURE McCormick		22b. DATE SIGNED	
22c. PHYSICIAN'S NAME (Type)		22d. ADDRESS	
23a. BURIAL, CREMATION, REMOVAL (Specify) burial		23b. DATE THEREOF 11/26/1960	
23c. NAME OF CEMETERY OR CREMATORY Church		23d. LOCATION (City, town, or county) (State) Stockton Md.	
24. FUNERAL DIRECTOR'S SIGNATURE Robert C. Stewart ADDRESS Salisbury Md		25a. REC'D BY REGISTRAR DEC 2 '60 25b. REGISTRAR'S SIGNATURE Charles E. Kane	

TO HOSPITAL: ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled out, the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Board of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.



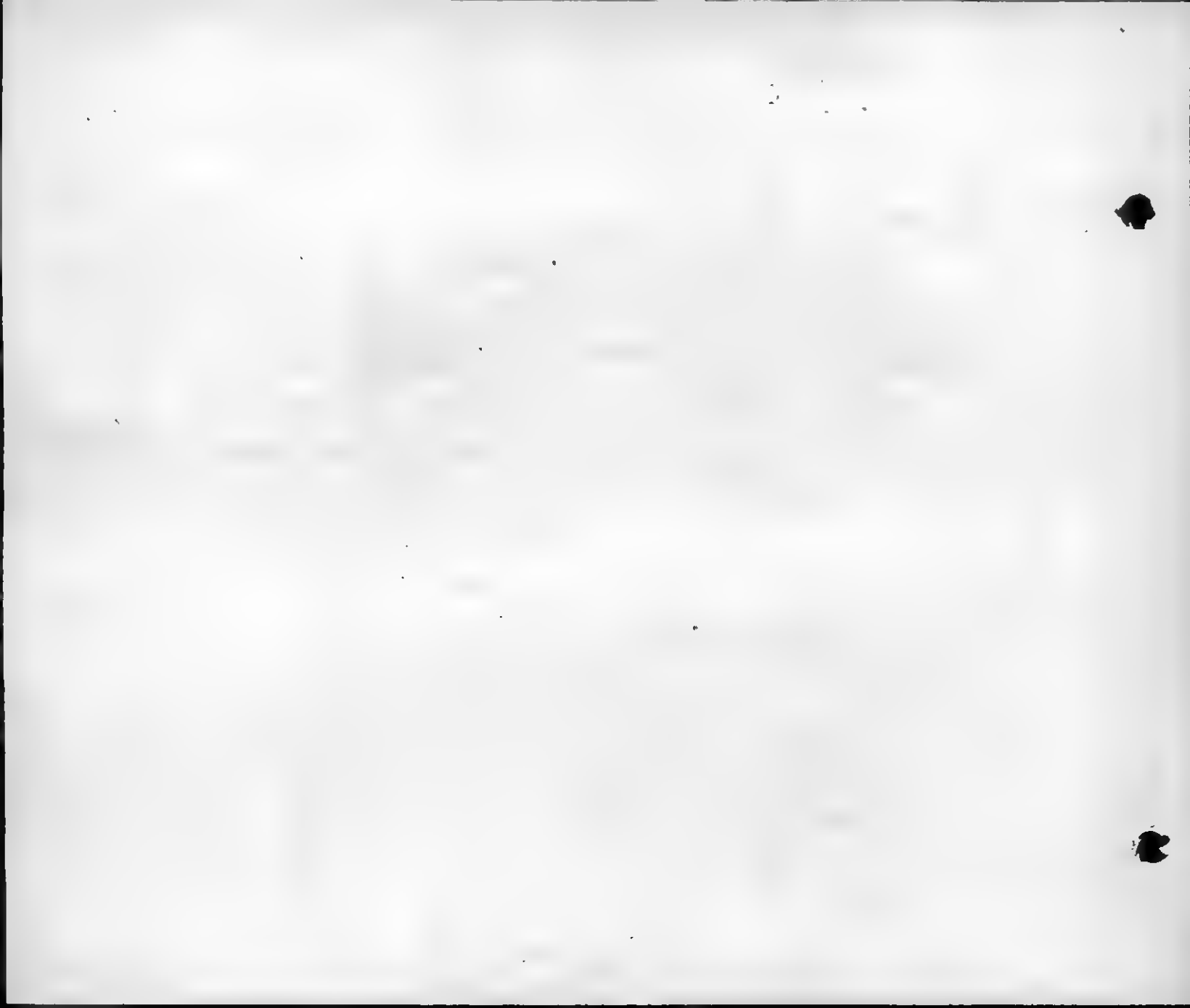
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MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND
CERTIFICATE OF DEATH

13184

13203

1. PLACE OF DEATH a. COUNTY <u>Wicomico</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Worcester</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Salisbury</u>				c. LENGTH OF STAY IN, 1b <u>6 Days</u>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Peninsula General</u>				d. STREET ADDRESS <u>Snow Hill</u>			
3. NAME OF DECEASED (Type or print) <u>W. Estelle</u> First Middle Last				4. DATE OF DEATH <u>November 2</u> Month Day Year <u>1960</u>			
5. SEX <u>Female</u>		6. COLOR OR RACE <u>White</u>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>April 14 - 1893</u>	
9. AGE (In years last birthday) <u>67</u>		10. IF UNDER 1 YEAR Months <u>6</u> Days <u>16</u>		11. IF UNDER 24 HRS Hours <u>6</u> Min. <u>18</u>			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u>				10b. KIND OF BUSINESS OR INDUSTRY <u>Own Home</u>			
11. BIRTHPLACE (State or foreign country) <u>Philadelphia, Pa.</u>				12. CITIZEN OF WHAT COUNTRY? <u></u>			
13. FATHER'S NAME <u>Daniel Lytle</u>				14. MOTHER'S MAIDEN NAME <u>Martha Stinger</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? <u>No</u> (If yes, give war or dates of service)				16. SOCIAL SECURITY NO <u></u>			
17. INFORMANT <u>Mr Paul D. Scarborough, Snow Hill, Md</u> Address <u></u>							
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c)]							
PART I DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <u>Cardiac Arrest (Stroke - Occlusion of Artery)</u>							
260X DUE TO <u>Hypertensive Cardiac Vascular Disease</u>							
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause (b) <u>Intercapillary Glomerulosclerosis and</u>							
(c) <u>Diabetes mellitus - Generalized Osteoporosis</u>							
PART II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u></u>							
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18)			
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <u>19</u>				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>			
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)				20f. (City or town) (County) (State)			
21. I certify that (I) (this hospital) attended the deceased from <u>Feb. 1958</u> to <u>Nov. 2, 1960</u> that (I) (we) last saw the deceased alive on <u>Nov. 1, 1960</u> , and that death occurred at <u>5 AM</u> , from the causes and on the date stated above							
22a. SIGNATURE <u>Thomas C. Hill Jr. M.D.</u>				22b. DATE SIGNED <u>11/2/60</u>			
22c. PHYSICIAN'S NAME (Type)				22d. ADDRESS <u>Pine Bluff Road, Salisbury, Md.</u>			
23a. BURIAL, CREMATION, 23b. DATE THEREOF REMOVAL (Specify) <u>Nov 4/60</u>				23c. NAME OF CEMETERY OR CREMATORY <u>Spring Hill Cemetery, Salisbury, Md.</u>			
24. FUNERAL DIRECTOR'S SIGNATURE <u>Clayton J. Gibbs</u>				25a. REC'D BY REGISTRAR <u></u> 25b. REGISTRAR'S SIGNATURE <u>Clayton J. Gibbs</u>			
DATE <u>NOV 3 '60</u>							



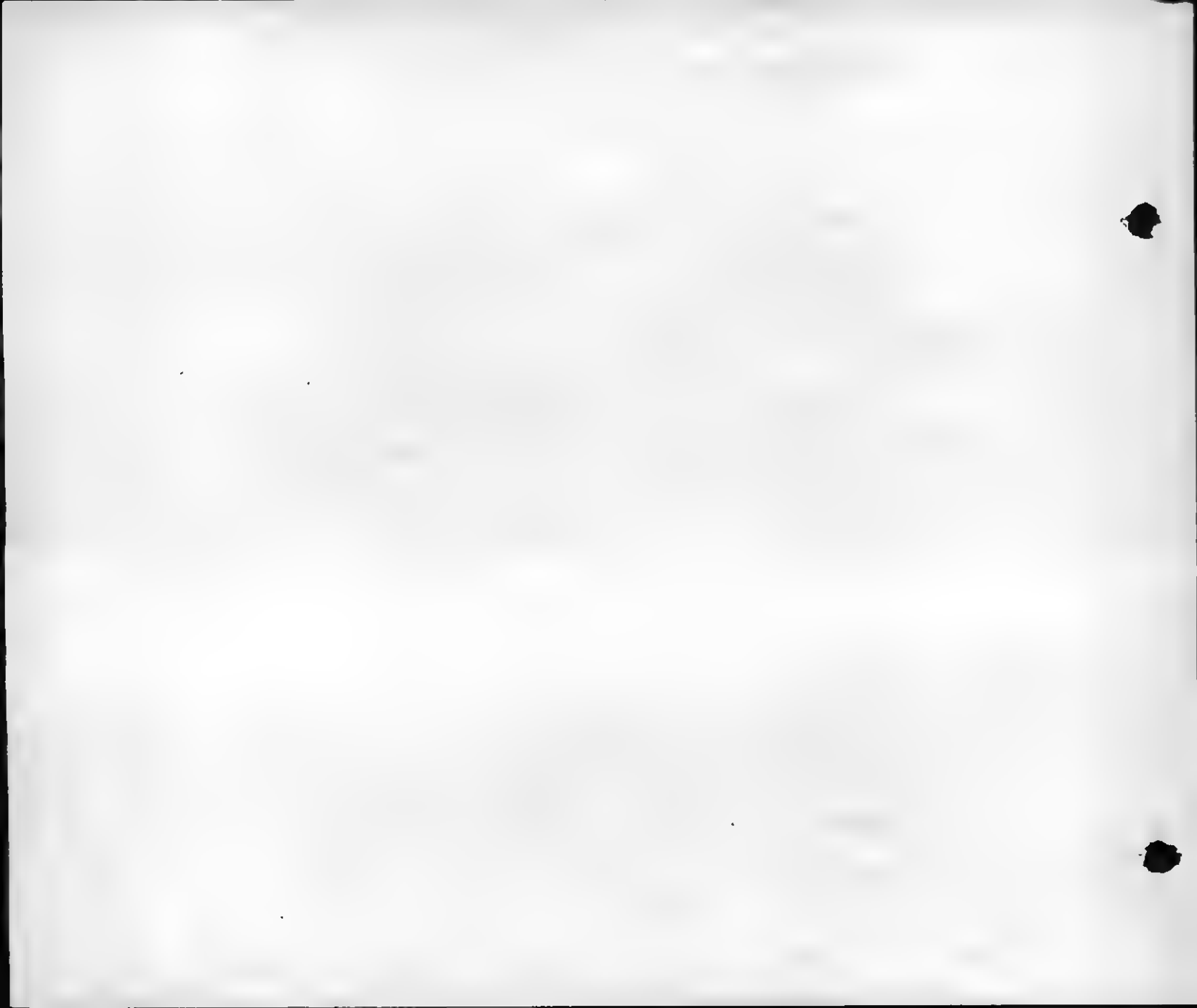
1
TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Board of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
ISM 9/59

13204
MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND
CERTIFICATE OF DEATH

13185

1. PLACE OF DEATH a. COUNTY <u>Wicomico</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution, Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Worcester</u> ✓	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Sallisbury</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Snow Hill, Box 39</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Peninsula General Hospital</u>		d. STREET ADDRESS <u>Rt. 2</u>	
3. NAME OF DECEASED (Type or print) <u>Inf</u> First Middle Last		4. DATE OF DEATH <u>November 6 - 1960</u> Month Day Year	
5. SEX <u>Male</u>	6. COLOR OR RACE <u>Colored</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>November 5, 1940</u>
9. AGE (In years last birthday) <u>20</u> yrs		10. UNDER 1 YEAR <input type="checkbox"/> IF UNDER 24 HRS <input type="checkbox"/>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>None</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>None</u>	
11. BIRTHPLACE (State or foreign country) <u>Maryland</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>	
13. FATHER'S NAME <u>?</u>		14. MOTHER'S MAIDEN NAME <u>Rebecca Sheppard</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>?</u>		16. SOCIAL SECURITY NO. <u>?</u>	
17. INFORMANT <u>Latte Sheppard</u>		Address <u>?</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: <u>776 X</u> IMMEDIATE CAUSE (a) <u>Prematurity - 740 grams -</u> DUE TO (b) <u>?</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (c) <u>?</u>		INTERVAL BETWEEN ONSET AND DEATH <u>?</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>?</u>		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <u>19</u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from <u>11/5</u> 19 <u>60</u> , to <u>11/6</u> 19 <u>60</u> that (I) (we) last saw the deceased alive on <u>11/6</u> 19 <u>60</u> and that death occurred at <u>?</u> M, from the causes and on the date stated above.			
22a. SIGNATURE <u>William C Morgan</u>		22b. DATE SIGNED <u>?</u>	
22c. PHYSICIAN'S NAME (Type)		22d. ADDRESS	
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial 11-9-60</u>		23b. DATE THEREOF	
23c. NAME OF CEMETERY OR CREMATORY <u>St James Cem</u>		23d. LOCATION (City, town, or county) (State) <u>Snow Hill, Md</u>	
24. FUNERAL DIRECTOR'S SIGNATURE <u>Booker M. West</u>		25a. REC'D BY REGISTRAR <u>?</u>	
ADDRESS <u>?</u>		25b. REGISTRAR'S SIGNATURE <u>?</u>	
DATE <u>NOV 14 60</u>			



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, the funeral director, page 3 should be detached for use as the burial-transit permit. These please remove carbon papers. Pages 1 and 2 should be filed with the State Board of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

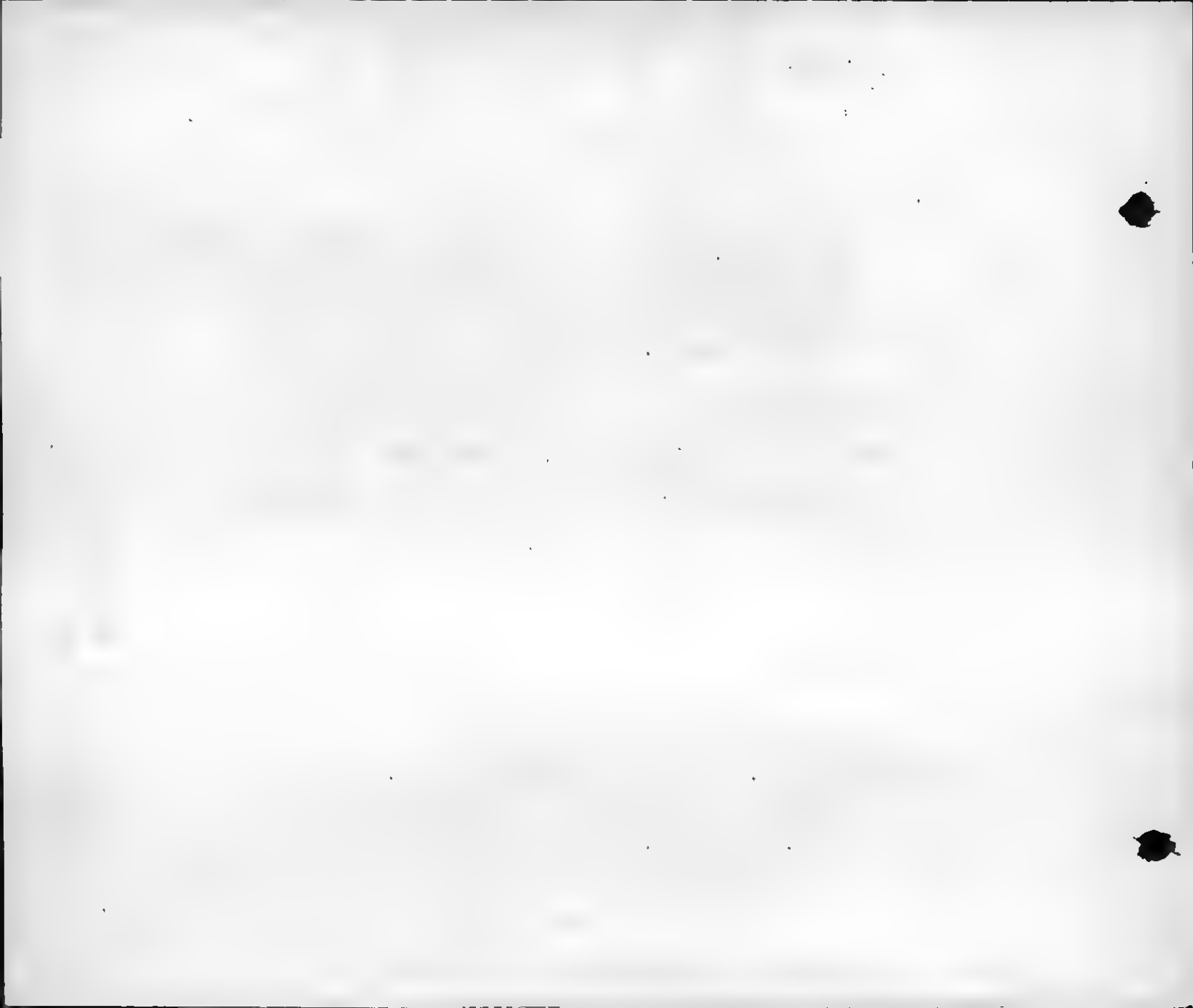
VR A15 (4)
15M 9/59

13205

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND
CERTIFICATE OF DEATH

13186

1 PLACE OF DEATH a. COUNTY Wicomico MARYLAND		2 USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Somerset ✓	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Salisbury		c. LENGTH OF STAY IN 1b 10 days	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Deer's Head State Hospital		d. STREET ADDRESS --	
3 NAME OF DECEASED (Type or print) First John Middle W. Last Smith Somers		4. DATE OF DEATH Month November Day 24 , Year 1960	
5 SEX Male	6 COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8 DATE OF BIRTH MAR-15 1869
9. AGE (In years last birthday) 91		10. IF UNDER 1 YEAR Months 0 Days 0 Hours 0 Min. 0	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Janitor		10b. KIND OF BUSINESS OR INDUSTRY Deal I. High School	
11. BIRTHPLACE (State or foreign country) Maryland		12 CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME John Smith Somers		14 MOTHER'S MAIDEN NAME Maggie Lawes	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (If yes, give war or dates of service) NO		16. SOCIAL SECURITY NO UNKNOWN	
17. INFORMANT Deer's Head Hospital Records, Salisbury, Md.		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) Arteriosclerotic cardiovascular disease 420.1 DUE TO Coronary thrombosis Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last (b) Arteriosclerosis general DUE TO (c) Arteriosclerosis general		INTERVAL BETWEEN ONSET AND DEATH Years 9hrs Years	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		19 WAS AUTOPSY PERFORMED? <input checked="" type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a m. p m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office, bridge, etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from 11/14/60 19 to 11/24 , 1960, that (I) (we) last saw the deceased alive on Nov. 24th 1960, and that death occurred at 6 P.M. from the causes and on the date stated above			
22a. SIGNATURE J. Juerman		22b. ADDRESS Deer's Head State Hospital Salisbury, Maryland	
22c. PHYSICIAN'S NAME (Type) J. Juerman, M. D.		22d. ADDRESS Deer's Head State Hospital Salisbury, Maryland	
23a. BURIAL, CREMATION, REMOVAL (Specify)		23b. DATE THEREOF Nov 27-1960	
23c. NAME OF CEMETERY OR CREMATORY St. John's C. M.		23d. LOCATION (City, town or county) (State) Salisbury, Md.	
24. FUNERAL DIRECTOR'S SIGNATURE Arthur S. Thomas		25. REC'D BY REG. STRAR DATE NOV 29 '60	
25b. REGISTRAR'S SIGNATURE Arthur S. Thomas			



CERTIFICATE OF DEATH

Reg. Dist. No.

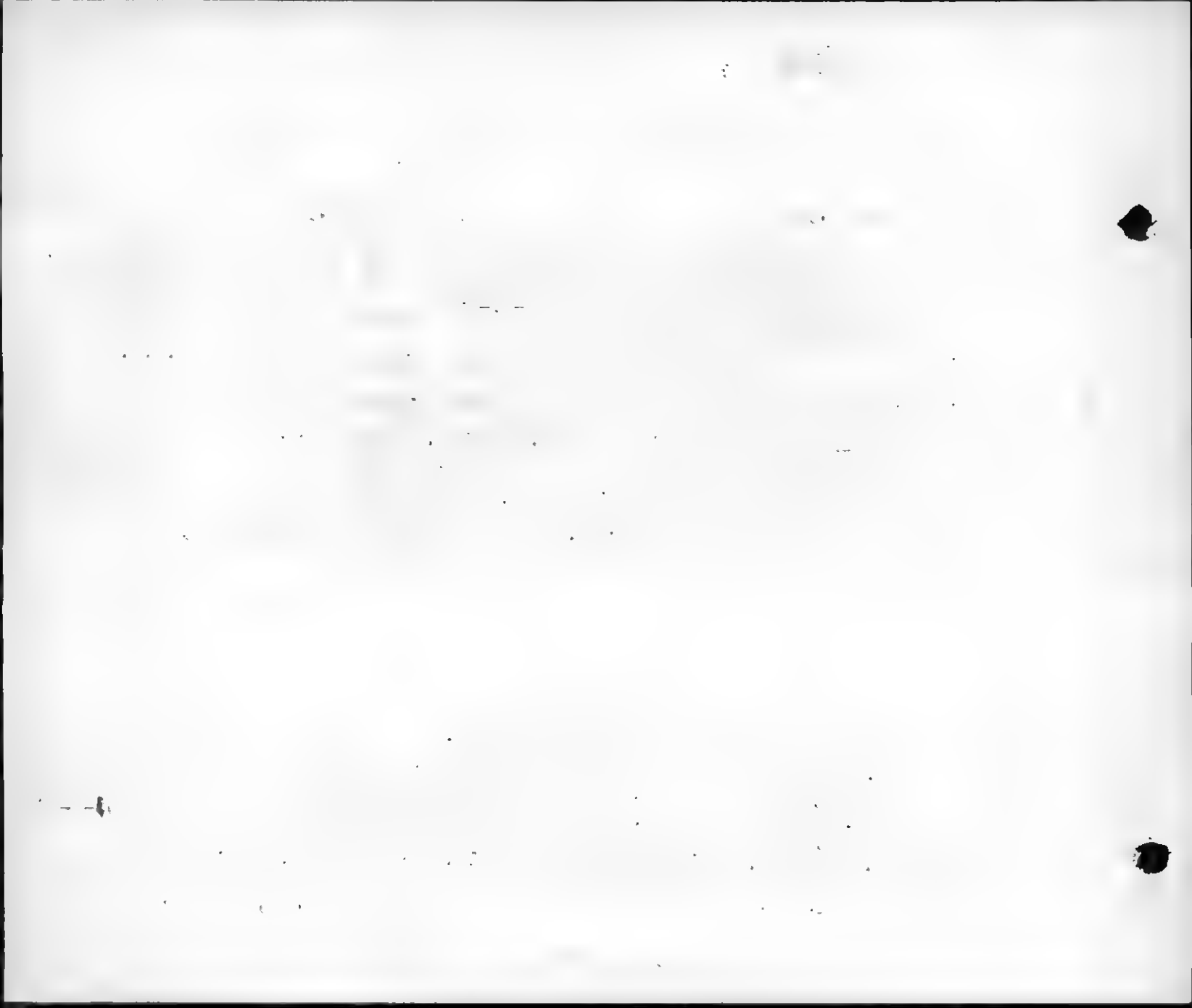
13187

13206

1. PLACE OF DEATH a. COUNTY Wicomico b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Salisbury c. LENGTH OF STAY IN 1b 45 yrs. d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION 700 Smith St.,		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Wicomico c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Salisbury d. STREET ADDRESS 700 Smith St., e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Middle Last HARRIETT ELLEN STEWART		4. DATE OF DEATH Month Day Year 11 6 1960	
5. SEX Female	6. COLOR OR RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 9-27-1881
9. AGE (In years last birthday) 79 yrs		10. IF UNDER 1 YEAR Months Days Hours Min.	11. IF UNDER 24 HRS Months Days Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) House Wife		10b. KIND OF BUSINESS OR INDUSTRY Own Home	
11. BIRTHPLACE (State or foreign country) Maryland		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME Joseph Washburn		14. MOTHER'S MAIDEN NAME Sarah Pryor	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) No		16. SOCIAL SECURITY NO 214-32-4170	
17. INFORMANT Mr. Frank M. Stewart, Same		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Coronary Thrombosis DUE TO (b) Arteriosclerosis (generalized) DUE TO (c) Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) INTERVAL BETWEEN ONSET AND DEATH Sudden			
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from 11-6 , 19 60 , to 11-6 , 19 60 , that I last saw the deceased alive on 11-6 , 19 60 , and that death occurred at 11 A.M. from the causes and on the date stated above. ADDRESS (Street, city or town, state) Salisbury, Maryland DATE SIGNED 11-7-60			
ACTUAL SIGNATURE Philip A. Insley		M.D. Salisbury, Maryland	
PHYSICIAN'S NAME (Type) Dr. Philip A. Insley, 116 East Main St., Salisbury, Maryland			
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial	22b. DATE THEREOF 11-8-1960	22c. NAME OF CEMETERY OR CREMATORY Shad Point Cemetery	22d. LOCATION (City, town, or county) (State) Salisbury, Maryland
23. FUNERAL DIRECTOR'S SIGNATURE Hill & Johnson Co. Salisbury, Maryland		24. REC'D BY REGISTRAR NOV 9 '60	
25. REGISTRAR'S SIGNATURE Arthur S. Kline			

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.



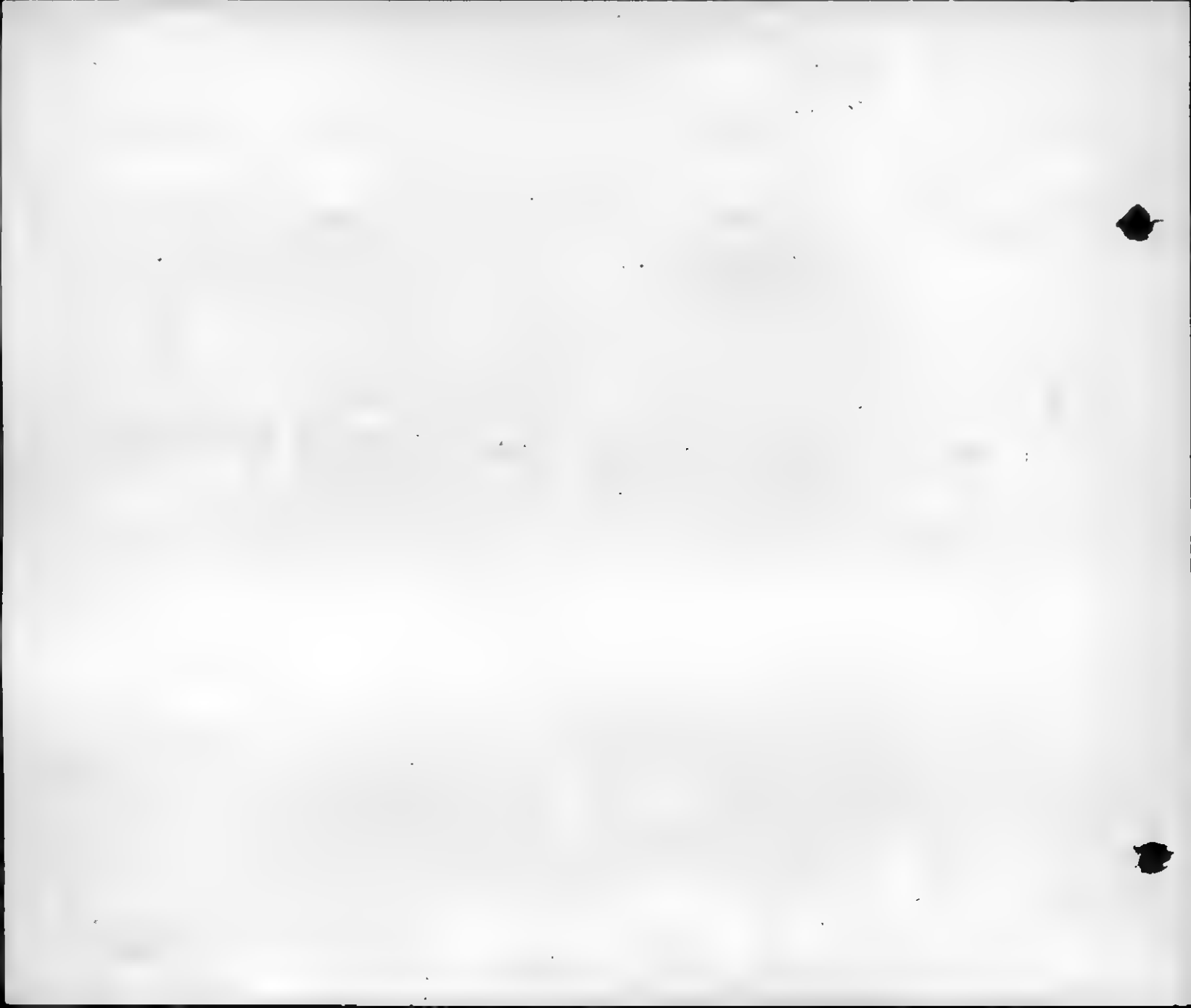
13207

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND

CERTIFICATE OF DEATH

13188

1 PLACE OF DEATH a COUNTY <u>111</u> MARYLAND		2 USUAL RESIDENCE (Where deceased lived. If institution Residence before admission) a STATE <u>Maryland</u> b COUNTY <u>Wicomico</u>	
b CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Salisbury</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Salisbury</u>	
d NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>General Hospital</u>		e IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <u>Hattie</u> Middle <u>L.</u> Last <u>SYKES</u>		4. DATE OF DEATH Month <u>1</u> Day <u>18</u> Year <u>1960</u>	
5. SEX <u>FEMALE</u>	6 COLOR OR RACE <u>NEGRO</u>	7 MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8 DATE OF BIRTH <u>February 14, 1919</u>
9. AGE (In years lost birthday) <u>41</u> yrs		10. IF UNDER 1 YEAR IF UNDER 24 HRS Months Days Hours Min	
10a USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Domestic</u>		10b. KIND OF BUSINESS OR INDUSTRY	
11. BIRTHPLACE (State or foreign country) <u>Virginia</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>Joseph Sykes</u>		14 MOTHER'S MAIDEN NAME <u>Rosa Harris</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>no.</u> (If yes, give war or dates of service)		16 SOCIAL SECURITY NO.	
17 INFORMANT <u>Sarah Sykes 704 East Road Salisbury Md.</u>		Address	
18 CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c)] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Cerebral Hemorrhage</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u></u> DUE TO (c) <u></u>		INTERVAL BETWEEN ONSET AND DEATH	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>	
20a ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part I of item 18)	
20c TIME OF INJURY Month, Day, Year Hour o m p. m. <u>1960</u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21 I certify that (I) (this hospital) attended the deceased from <u>10-18</u> <u>1960</u> to <u>11-8</u> <u>1960</u> , that (I) (we) last saw the deceased alive on <u>10-8</u> <u>1960</u> , and that death occurred at <u>4:15</u> M, from the causes and on the date stated above			
22a SIGNATURE <u>Carrie I. Leam</u>		22b DATE SIGNED	
22c PHYSICIAN'S NAME (Type) <u>CLARENCE H. EARN</u>		22d ADDRESS	
23a BURIAL, CREMATION, REMOVAL (Specify) <u>burial</u>		23b. DATE THEREOF <u>11/12/1960</u>	
23c NAME OF CEMETERY OR CREMATORY <u>green acres</u>		23d LOCATION (City, town or county) (State) <u>Salisbury Md.</u>	
24 FUNERAL DIRECTOR'S SIGNATURE <u>Clinton F. Stewart</u>		25a REC'D BY REGISTRAR <u>NOV 18 '60</u>	
25b REGISTRAR'S SIGNATURE <u>Arthur S. Evans</u>			



MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND

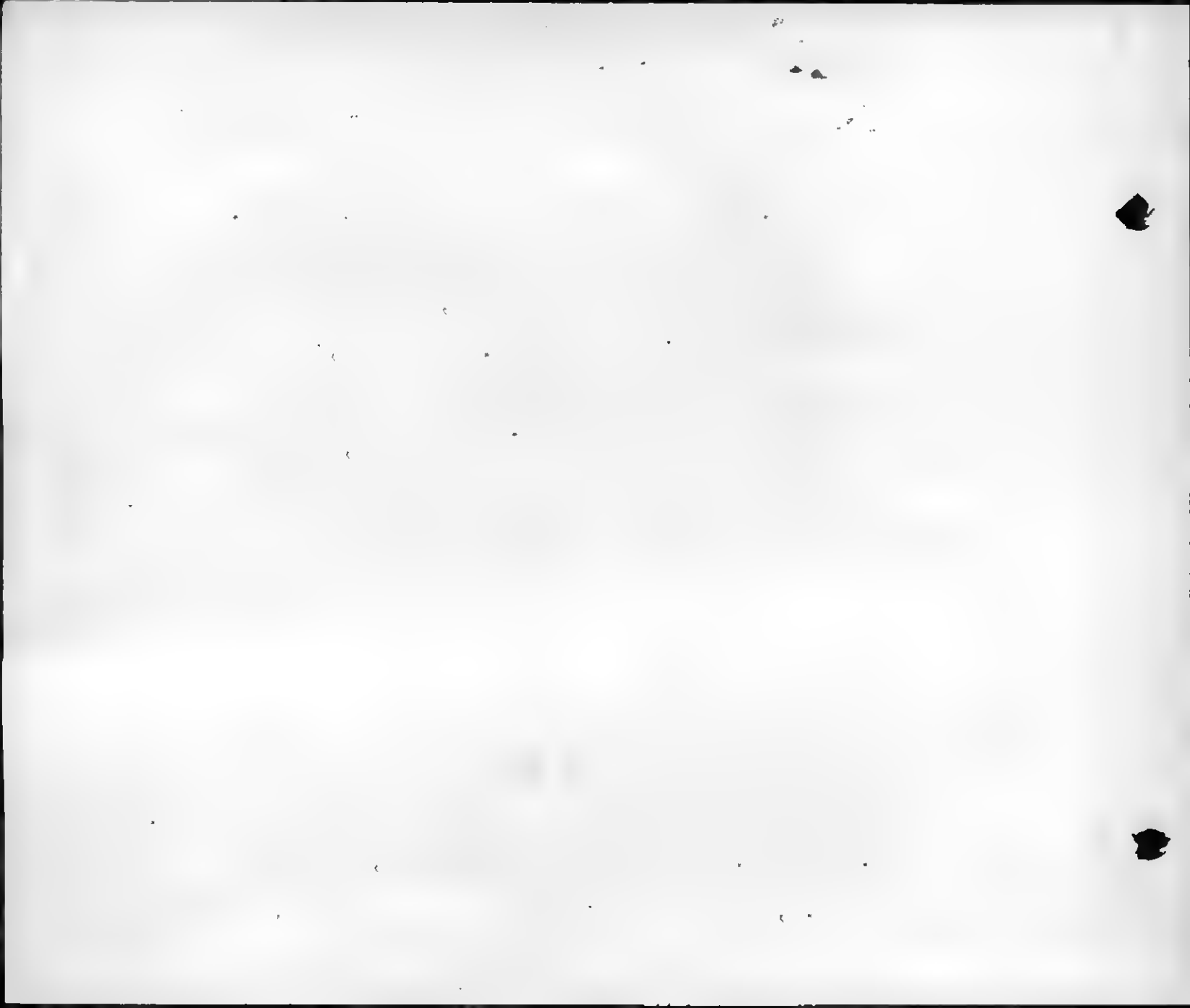
13208

CERTIFICATE OF DEATH

13189

1 PLACE OF DEATH a. COUNTY Wicomico MARYLAND		2 USUAL RESIDENCE (Where deceased lived. If institution Residence before admission) a. STATE Maryland b. COUNTY Wicomico	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Salisbury		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Salisbury	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Pen Gen. Hospital		d. STREET ADDRESS Ocean City Blvd.	
3 NAME OF DECEASED (Type or print) First JAMES Middle WINFIELD Last TAYLOR		4. DATE OF DEATH Month NOVEMBER Day 30th Year 1960	
5 SEX Male	6 COLOR OR RACE White	7 MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8 DATE OF BIRTH Jan 10, 1886
9 AGE (In years last birthday) 74 yrs.		10 IF UNDER 1 YEAR Months 10 Days 20 Hours Min 	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Retired Owner & Manager-Taylor Oil Co.		10b. KIND OF BUSINESS OR INDUSTRY Quantico, Maryland	
11 BIRTHPLACE (State or foreign country) U S A		12 CITIZEN OF WHAT COUNTRY? U S A	
13 FATHER'S NAME Wesley Taylor		14. MOTHER'S MAIDEN NAME Georgia Hurley	
15 WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes no or unknown) Unk (If yes, give war or dates of service)		16. SOCIAL SECURITY NO Informant	
17. INFORMANT Mrs. Mary West Taylor (Wife)		Address Ocean City Blvd Salisbury, Maryland	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) 444X Congestive Heart Failure DUE TO (b) Arteriosclerosis Conditions, if any, which gave rise to immediate cause (c), stating the underlying cause lost. (c) 			INTERVAL BETWEEN ONSET AND DEATH 8 days ? year
PART II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) Hy pertension			
19 WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18) N/A	
20c. TIME OF INJURY Month, Day, Year Hour a. m. N/A p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) N/A		20f. (City or town) N/A (County) (State)	
21 I certify that (I) (this hospital) attended the deceased from July 28, 1960 to Nov 30, 1960 , that (I) met last saw the deceased alive on Nov 30, 1960 , and that death occurred at 10:20 PM , from the causes and on the date stated above.			
22a SIGNATURE Dr. Robert T. Adkins		22b DATE SIGNED Dec. 3/1960	
22c PHYSICIAN'S NAME (Type) Dr. Robert T. Adkins		22d. ADDRESS Fruitland, Maryland	
23a BURIAL, CREMATION, REMOVAL (Specify) Burial		23b DATE THEREOF Dec. 3, 1960	
23c NAME OF CEMETERY OR CREMATORY Allen Cemetery		23d. LOCATION (City, town, or county) (State) Allen, Maryland	
24 FUNERAL DIRECTOR'S SIGNATURE HOLLOWAY & COMPANY		ADDRESS SALISBURY MARYLAND	
25a REC'D BY REGISTRAR DEC 6 '60		25b REGISTRAR'S SIGNATURE Arthur S. Kline	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Board of Health prior to burial, cremation or removal, and in any event, within 72 hours after death.



TO HOSPITAL: ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filled with the State Board of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

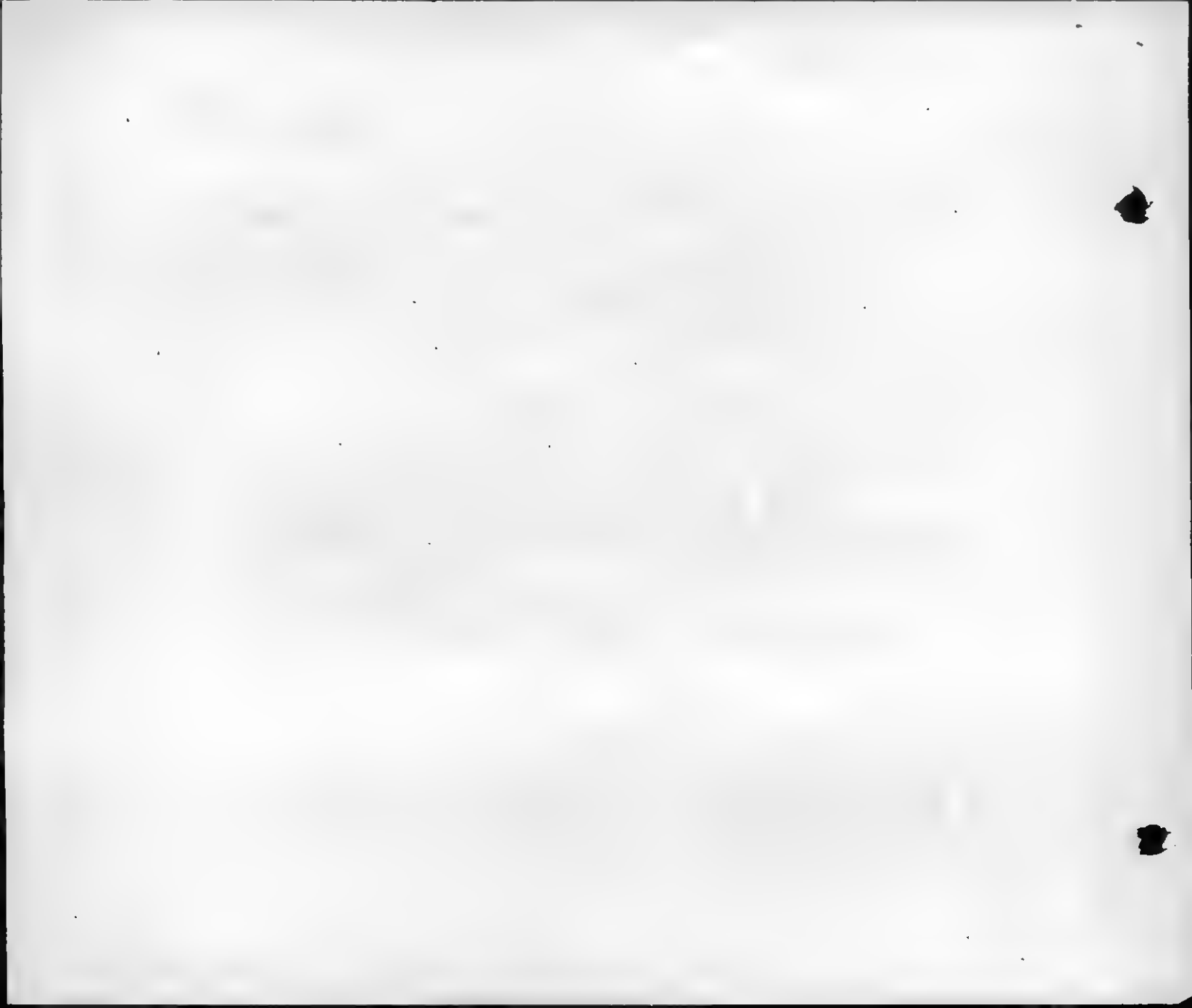
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15M 9/59

13209

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND
CERTIFICATE OF DEATH

13150

1. PLACE OF DEATH a. COUNTY WICOMICO b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) SALISBURY		2. USUAL RESIDENCE (Where deceased lived. If institution, residence before admission) a. STATE MARYLAND b. COUNTY WORCESTER c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) POCOMOKE CITY	
c. LENGTH OF STAY IN 1b 12 DAYS		d. STREET ADDRESS 602 LINDEN AVENUE	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION PENINSULA GENERAL HOSPITAL		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First ELSIE Middle G. Last THOMAS		4. DATE OF DEATH Month NOVEMBER Day 4 Year 1960	
5. SEX FEMALE	6. COLOR OR RACE WHITE	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH OCT. 6, 1891
9. AGE (In years last birthday) 69 yrs		10. IF UNDER 1 YEAR: Months 6 Days 9 Hours 15 Min 00	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) HOUSEWIFE		10b. KIND OF BUSINESS OR INDUSTRY —	
11. BIRTHPLACE (State or foreign country) MARYLAND		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME BENJAMIN WILLIAMS		14. MOTHER'S MAIDEN NAME UNKNOWN	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) NO		16. SOCIAL SECURITY NO. —	
17. INFORMANT MR. OBED W. THOMAS, 602 LINDEN AVE, POCOMOKE CITY, MD.		18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c))	
PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) Cerebral Hemorrhage		INTERVAL BETWEEN ONSET AND DEATH 12 days	
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) Cerebral Arteriosclerosis		(c) —	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) —			
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)	
20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18)		20c. TIME OF INJURY Month, Day, Year Hour a. m. 10/23 p. m. 1960	
20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) 10/23	
20f. (City or town) POCOMOKE CITY (County) MARYLAND (State) MARYLAND		21. I certify that (I) (this hospital) attended the deceased from 10/23 19 60 to 11/4 19 60 , that (I) (we) last saw the deceased alive on 11/3 19 60 , and that death occurred at 12:35 M, from the causes and on the date stated above	
22a. SIGNATURE David J. Gilmore		22b. DATE SIGNED 11-5-60	
22c. PHYSICIAN'S NAME (Type) DAVID J. GILMORE MD.		22d. ADDRESS SALISBURY, MARYLAND	
23a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL		23b. DATE THEREOF 11-6-60	
23c. NAME OF CEMETERY OR CREMATOR FIRST BAPTIST		23d. LOCATION (City, town, or county) POCOMOKE CITY, MARYLAND (State) MARYLAND	
24. FUNERAL DIRECTOR'S SIGNATURE Robert H. Watson		25a. REC'D BY REGISTRAR NOV 8 '60	
ADDRESS POCOMOKE CITY, MD.		25b. REGISTRAR'S SIGNATURE William E. H. H. H.	

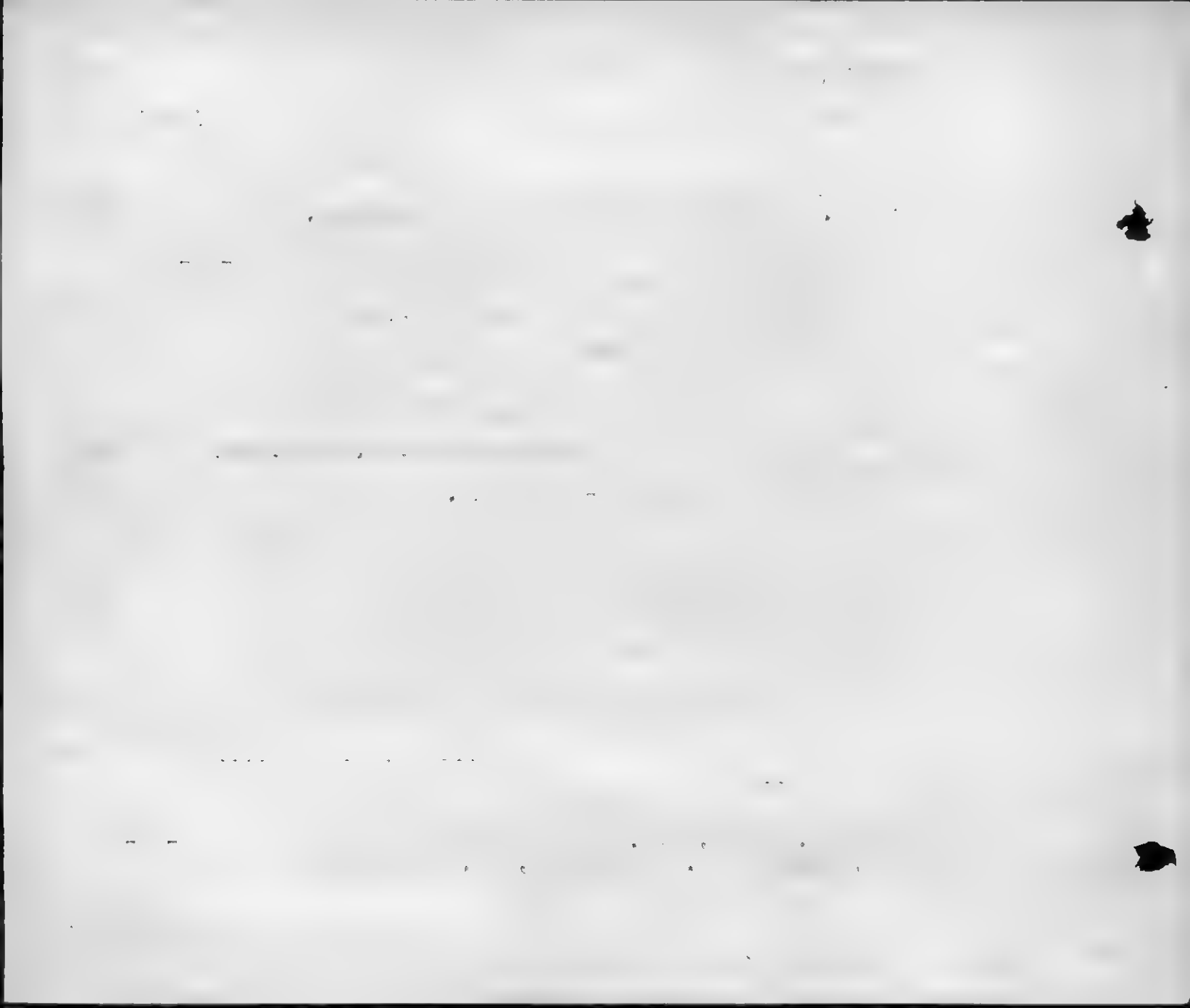


TO THE PUBLIC MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If a body is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the Medical Director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM-3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH
 Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

1. PLACE OF DEATH a. COUNTY Wicomico		2. USUAL RESIDENCE (Where deceased lived, if institution. Residence before adm. ssion) a. STATE Maryland		b. COUNTY Wicomico	
b. CITY OR TOWN (If out of corporate limits write RURAL and give nearest town) Salisbury		c. LENGTH OF STAY IN 1b		c. CITY OR TOWN (If out of corporate limits, write RURAL and give nearest town) Salisbury	
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) Kiowa Ave.		d. STREET ADDRESS Kiowa Ave.		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) Edward		First Edward		Middle Twilley	
5. SEX M		6. COLOR OR RACE C		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	
8. DATE OF BIRTH August 25, 1921		9. AGE (In years last birthday) 39 yrs.		10. IF UNDER 1 YEAR Months 11 Days 11	
11. BIRTHPLACE (State or foreign country) Maryland		12. CITIZEN OF WHAT COUNTRY? U.S.A.		13. FATHER'S NAME George Twilley	
14. MOTHER'S MAIDEN NAME Sarah Jonson		15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give year and date of service) yes		16. SOCIAL SECURITY NO. Anna J. Price Kiowa Ave Salisbury	
17. INFORMANT Anna J. Price Kiowa Ave Salisbury		18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) 191X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. DUE TO PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I: Broncho-pneumonia.		INTERVAL BETWEEN ONSET AND DEATH 144	
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING CAUSE OF DEATH <input type="checkbox"/>		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18)		19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
20c. TIME OF INJURY Month, Day, Year Hour a.m. 19 p.m.		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town)		(County)		(State)	
21. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from. Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>					
CHIEF MEDICAL EXAMINER <input type="checkbox"/>					
ASS STANT MEDICAL EXAMINER <input type="checkbox"/>					
DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>					
DATE SIGNED 11-18-60					
EXAMINER'S NAME (Type) Earl H. Royer, M.D. 407 Camden Ave. Salisbury, Md.					
22a. BURIAL, CREMATION, REMOVAL (Specify) burial					
22b. DATE THEREOF 11/15/1960					
22c. NAME OF CEMETERY OR CREMATORY green acres					
22d. LOCATION (City, town, or country) Salisbury Md.					
23. FUNERAL DIRECTOR Clinton F. Stewart Salisbury Md.					
24a. REC'D BY REGISTRAR NOV 23 '60					
24b. REGISTRAR'S SIGNATURE Clifton S. Kneass					



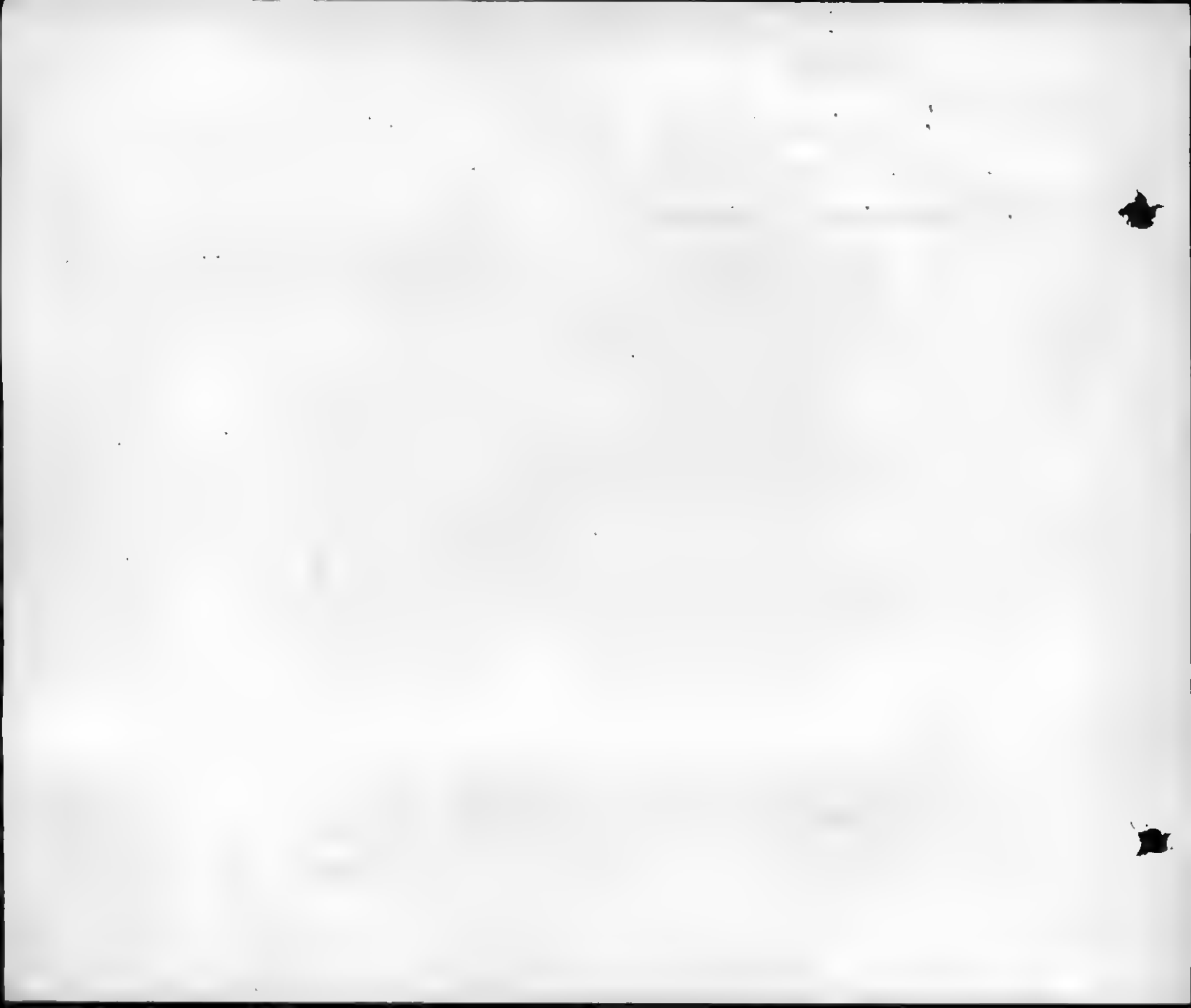
may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Board of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND
CERTIFICATE OF DEATH

13211

13192

1 PLACE OF DEATH a. COUNTY <u>Wicomico</u> MARYLAND				2 USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Worcester</u> ✓			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Salisbury</u>				c. LENGTH OF STAY IN 1b <u>BOULIN</u>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>PENINSULA General</u>				d. STREET ADDRESS <u>222 X</u>			
3 NAME OF DECEASED (Type or print) First <u>William</u> Middle <u>tyndall</u> Last <u>tyndall</u>				4. DATE OF DEATH Month <u>November</u> Day <u>9</u> Year <u>1960</u>			
5 SEX <u>M</u>	6. COLOR OR RACE <u>C</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH	9. AGE (In years last birthday) <u>55+</u> yrs	IF UNDER 1 YEAR Months Days Hours Min.	IF UNDER 24 HRS Hours Min.	• IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
10a USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>LABORER</u>		10b KIND OF BUSINESS OR INDUSTRY <u>—</u>		11 BIRTHPLACE (State or foreign country) <u>GEORGETOWN DEL</u>		12 CITIZEN OF WHAT COUNTRY? <u>USA</u>	
13. FATHER'S NAME <u>unknown</u>				14 MOTHER'S MAIDEN NAME <u>unknown</u>			
15. WAS DECEASED EVER IN U S ARMED FORCES? (Yes, no, or unknown)		16 SOCIAL SECURITY NO <u>—</u>		17 INFORMANT <u>MR. CHARLES COATES</u>		Address <u>BERLIN MD</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) DUE TO <u>Acute Coronary</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last (b) DUE TO <u>Acute Retention of Urine</u> (c) DUE TO <u>Cystitis, Pyelitis</u>							INTERVAL BETWEEN ONSET AND DEATH <u>10 days</u>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>not known</u>							19 WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18.) <u>—</u>					
20c TIME OF INJURY Month, Day, Year Hour o m p m <u>19</u>	20d INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office, bldg., etc.) <u>—</u>		20f. (City or town) <u>—</u>		(County) (State)	
21. I certify that (I) (this hospital) attended the deceased from <u>Oct 29</u> 19 <u>60</u> to <u>Nov 9</u> 19 <u>60</u> that (I) (we) last saw the deceased alive on <u>Nov 9</u> 19 <u>60</u> , and that death occurred at <u>11:30</u> M, from the causes and on the date stated above							
22a SIGNATURE <u>Herbert S. Sembly</u>		M.D. ATTENDING PHYS <input checked="" type="checkbox"/> MED DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22b DATE SIGNED <u>11/11/60</u>			
22c PHYSICIAN'S NAME (Type) <u>G. Herbert Sembly, M.D.</u>		22d ADDRESS <u>400 E. Church St Salisbury, Md</u>					
23a BURIAL, CREMATION, REMOVAL (Specify) <u>BURIAL</u>	23b DATE THEREOF <u>11/11/60</u>	23c NAME OF CEMETERY OR CREMATORY <u>ST. PAULS</u>		23d LOCATION (City, town, or county) <u>BERLIN</u>		(State) <u>MD</u>	
24 FUNERAL DIRECTOR'S SIGNATURE <u>Anna S. Burby</u>				25a. REC'D BY REGISTRAR DATE <u>NOV 14 60</u>		25b. REGISTRAR'S SIGNATURE <u>Arthur S. Frame</u>	



TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. The funeral director should please remove carbon papers. Pages 1 and 2 should be filed with the State Board of Health prior to burial, cremation, or removal, and at any event, within 72 hours after death.

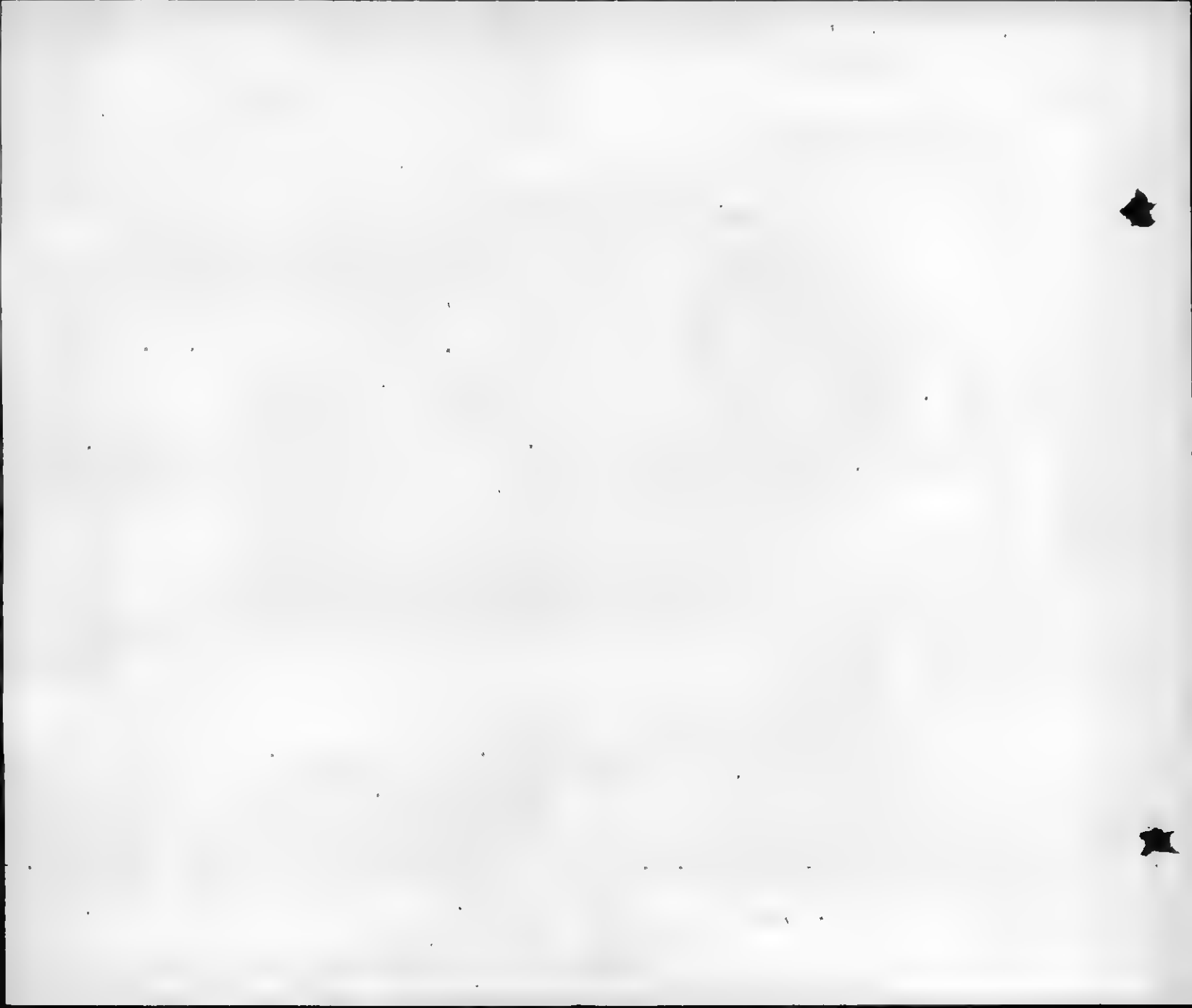
MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND
CERTIFICATE OF DEATH

13193

13212

1. PLACE OF DEATH a. COUNTY Wicomico MARYLAND				2. USUAL RESIDENCE (Where deceased lived If institution Residence before admission) a. STATE Maryland b. COUNTY Queen Anne's ✓			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Salisbury			c. LENGTH OF STAY IN 1b 17 days			c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Sudlersville	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Deer's Head State Hospital				d. STREET ADDRESS 1722			
3. NAME OF DECEASED (Type or print) First Iola Middle Julia Last Warner				4. DATE OF DEATH Month November Day 20 Year 19 60			
5. SEX Female	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input checked="" type="checkbox"/>	8. DATE OF BIRTH July 10, 1900		9. AGE (In years last birthday) yrs 60	F UNDER 1 YEAR Months 20 Days 20 Hours 19 Min 60	IF UNDER 24 HRS
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife		10b. KIND OF BUSINESS OR INDUSTRY Home		11. BIRTHPLACE (State or foreign country) Del.		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME John H. Pratt				14. MOTHER'S MAIDEN NAME Clementine Voshell			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No		16. SOCIAL SECURITY NO 221-20-4680		17. INFORMANT Mrs. George Everett, Sudlersville, Md.			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Bronchial pneumonia 491X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) Brain tumor							INTERVAL BETWEEN ONSET AND DEATH 24 hrs
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)							19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>
20c. TIME OF INJURY Month, Day, Year Hour a. m. 19 p. m.		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from Nov. 3, 1960 to Nov. 20, 1960 . that (I) (we) last saw the deceased alive on Nov. 20, 1960 , and that death occurred at 7:05 P.M. M, from the causes and on the date stated above.							
22a. SIGNATURE L. V. Maldve				M.D. ATTENDING PHYS <input type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS <input checked="" type="checkbox"/>		22b. DATE SIGNED 11/21/60	
22c. PHYSICIAN'S NAME (Type) L. V. Maldve, M. D.				22d. ADDRESS Deer's Head State Hospital; Salisbury, Md.			
23a. BURIAL CREMATION REMOVAL (Specify) Burial		23b. DATE THEREOF Nov. 23, 1960		23c. NAME OF CEMETERY OR CREMATORY Sudlersville Cemetery		23d. LOCATION (City, town, or county) (State) Sudlersville, Md.	
24. FUNERAL DIRECTOR'S SIGNATURE Edward Fellows				25a. REC'D BY REG. STRAR DATE NOV 28 '60		25b. REGISTRAR'S SIGNATURE Anthony S. Kraus	

22



MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND

CERTIFICATE OF DEATH

Item 7 Film 0275 11-22-60 et

13213

13194

1 PLACE OF DEATH a. COUNTY Wicomico MARYLAND		2 USUAL RESIDENCE (Where deceased lived. If institution Residence before admission) a. STATE Maryland b. COUNTY Wicomico	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Salisbury		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Sharptown, Md.	
c. LENGTH OF STAY IN lb 1015 days		d. STREET ADDRESS Water St.	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Deer's Head State Hospital		e. IS RESIDENCE ON A FARM YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3 NAME OF DECEASED (Type or print) First Lena Elizabeth Middle Wheatley Last Wheatley		4. DATE OF DEATH Month November Day 15 Year 1960	
5 SEX Female	6 COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH Mar 12, 1971
9. AGE (In years last birthday) 9 yrs		10. IF UNDER 1 YEAR Months 9 Days 15 Hours 15 Min. 15	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Garment operator		10b. KIND OF BUSINESS OR INDUSTRY none	
11. BIRTHPLACE (State or foreign country) Md.		12. CITIZEN OF WHAT COUNTRY? US.	
13. FATHER'S NAME John S. Vickers		14. MOTHER'S MAIDEN NAME Sarah Ellis	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) no		16. SOCIAL SECURITY NO. 110	
17. INFORMANT Donald L. Wheatley, Sharptown, Md.		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) Bronchopneumonia DUE TO 491X Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) DUE TO (c) DUE TO PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) Arteriosclerosis, general INTERVAL BETWEEN ONSET AND DEATH 24 hrs.			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18)	
20c. TIME OF INJURY Month Feb. Day 3 Year 1958 Hour 8:30 a.m. A.M.		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from Feb. 3, 1958 to Nov. 15, 1960 , that (I) (we) last saw the deceased alive on Nov. 15, 1960 , and that death occurred at 8:30 A.M. from the causes and on the date stated above.			
22a. SIGNATURE L. V. Maldve, M. D.		22b. DATE 11/15/60	
22c. PHYSICIAN'S NAME (Type)		22d. ADDRESS Deer's Head State Hospital; Salisbury, Md.	
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial	23b. DATE THEREOF 11-19-60	23c. NAME OF CEMETERY OR CREMATORY Cokebury Church	23d. LOCATION (City, town, or county) (State) Delaware, Delaware
24. FUNERAL DIRECTOR'S SIGNATURE Smith Funeral Home		25a. REC'D BY REGISTRAR NOV 18 '60	
ADDRESS Sharptown,		25b. REGISTRAR'S SIGNATURE Arthur L. Hume	

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filled with the State Board of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.



MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND
CERTIFICATE OF DEATH

13214

13195

1. PLACE OF DEATH a. COUNTY <u>Wicomico</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived if institution Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Wicomico</u>			
b. CITY OR TOWN (If outside corporate limits write RURAL and give nearest town) <u>Salisbury</u>				c. LENGTH OF STAY IN TB <u> </u>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Peninsula General</u>				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>			
3. NAME OF DECEASED (Type or print) <u>Dwight</u> First <u>White</u> Middle Last				4. DATE OF DEATH <u>November 1</u> 19 <u>60</u> Month Day Year			
5. SEX <u>Male</u>	6. COLOR OF RACE <u>negr</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>Oct 30 - 1960</u>	9. AGE (In years last birthday) <u>2 day</u>	IF UNDER 1 YEAR Months Days	IF UNDER 24 HRS Hours Min	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u> </u>			10b. KIND OF BUSINESS OR INDUSTRY <u> </u>		11. BIRTHPLACE (State or foreign country) <u>Salisbury md</u>		
12. CITIZEN OF WHAT COUNTRY? <u>U.S.A</u>							
13. FATHER'S NAME <u>Cristopher Pinder</u>				14. MOTHER'S MAIDEN NAME <u>Lettie White</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u> </u> (If yes, give war or dates of service)				16. SOCIAL SECURITY NO. <u> </u>		17. INFORMANT <u>Lettie White</u> Address <u> </u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <u>Cerebral Hemorrhage and Central ischemia</u> <u>160.0</u> DUE TO (b) <u>Acute and chronic Fetal Anoxia</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (c) <u> </u> PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u> </u>							INTERVAL BETWEEN ONSET AND DEATH <u> </u>
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)							
20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18)							
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m.	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town)	(County)	(State)		
21. I certify that (I) (this hospital) attended the deceased from <u>Oct 30th</u> 19 <u>60</u> to <u>Nov 1st</u> 19 <u>60</u> , that (I) (we) last saw the deceased alive on <u>Nov 1st</u> 19 <u>60</u> , and that death occurred at <u>4:35</u> AM, from the causes and on the date stated above							
22a. SIGNATURE <u>William C. Morgan</u>				22b. DATE SIGNED <u> </u>			
22c. PHYSICIAN'S NAME (Type)				22d. ADDRESS			
23a. BURIAL, CREMATION, REMOVAL (Specify)		23b. DATE THEREOF		23c. NAME OF CEMETERY OR CREMATORY		23d. LOCATION (City, town, or county) (State)	
<u>Burial</u>		<u>11-2-60</u>		<u>md Calvary</u>		<u>Frederick md</u>	
24. FUNERAL DIRECTOR'S SIGNATURE <u>Booker McQuest</u> ADDRESS <u> </u>				25a. REC'D BY REGISTRAR <u> </u> DATE <u>NOV 9 '60</u>		25b. REGISTRAR'S SIGNATURE <u> </u>	

I, ATTENDING PHYSICIAN, The law requires that the death certificate be executed within 24 hours after death. Page 4
 may be retained by the hospital or attending physician.
 TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filled with the State Board of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours of death. Page 4 may be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Board of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

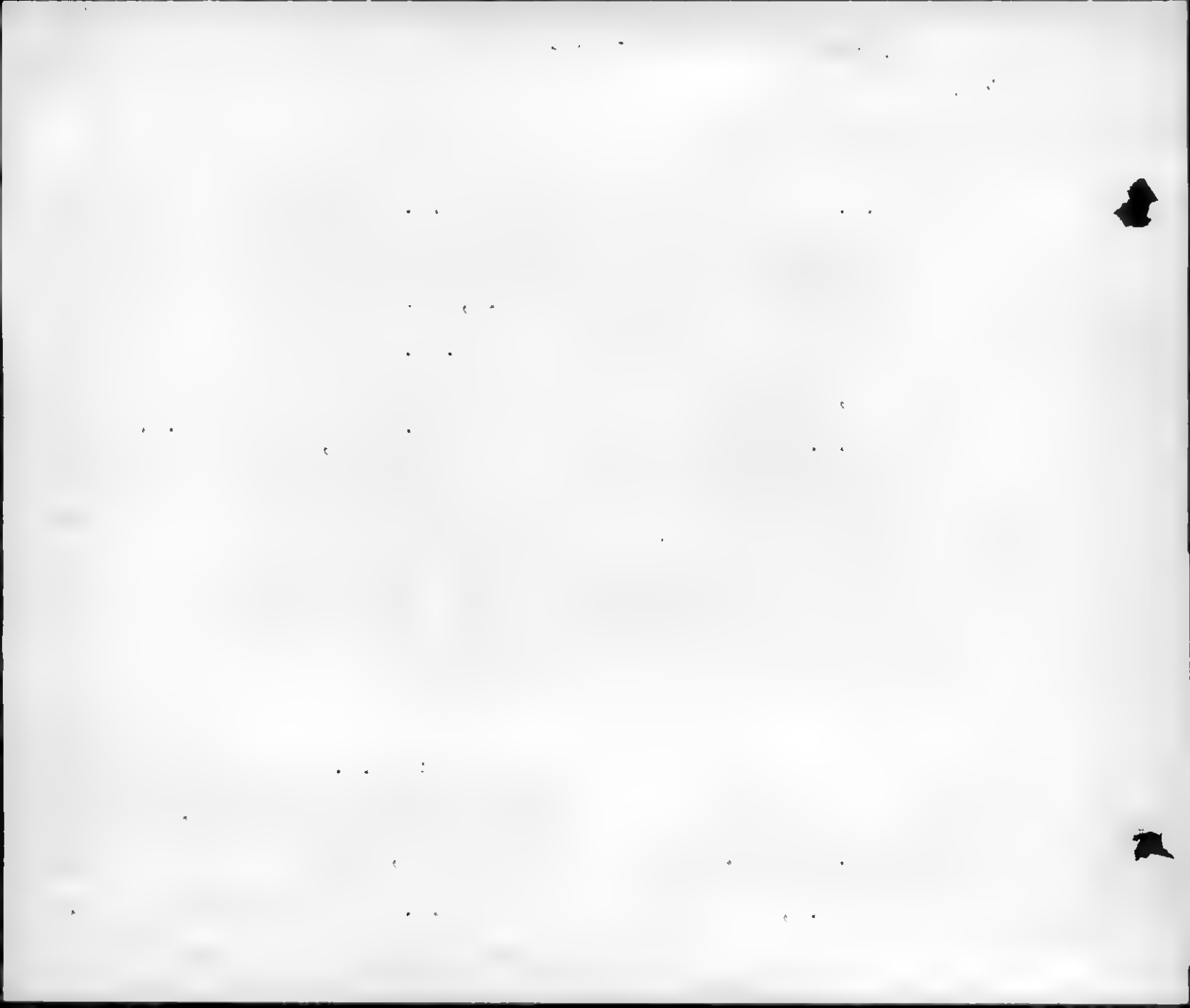
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15M 9/59

13225

13196

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND
CERTIFICATE OF DEATH

1. PLACE OF DEATH a. COUNTY Wicomico MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution Residence before admission) a. STATE Maryland b. COUNTY Wicomico			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) (Rural) Parsonsburg				c. LENGTH OF STAY IN 1b X Parsonsburg (Rur 1)			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION R.D.# 1 (Wingo)				d. STREET ADDRESS R.D.# 1 (Wingo)			e. IS RESIDENCE ON A FARM? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>
3. NAME OF DECEASED (Type or print) First EDUAR Middle ALTON Last IMBROW				4. DATE OF DEATH Month NOV Day 6 Year 1960			
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH Dec. 4, 1927	9. AGE (In years last birthday) 72 yrs	IF UNDER 1 YEAR Months Days Hours Min	IF UNDER 24 HRS Months Days Hours Min	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Farmer		10b. KIND OF BUSINESS OR INDUSTRY Farming		11. BIRTHPLACE (State or foreign country) Wico. Co. (Wingo) Maryland		12. CITIZEN OF WHAT COUNTRY? U S A	
13. FATHER'S NAME Greensbury, Imbrow				14. MOTHER'S MAIDEN NAME Lida Ellis			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) YES		16. SOCIAL SECURITY NO 1-1-1-1-1-1-1-1		17. INFORMANT F. Imbrow (Sister) R.D.# 1 (Wingo) Parsonsburg, Maryland			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c)] PART I DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) (Myocardial infarction) Coronary thrombosis 420-1 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last (b) Arteriosclerosis Hypertension DUE TO (c)						INTERVAL BETWEEN ONSET AND DEATH 3 days	
PART II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18.) N/A					
20c. TIME OF INJURY Hour a. m. p. m. N/A 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) N/A		20f. (City or town) (County) (State) N/A	
21. I certify that (I) (this hospital) attended the deceased from 1956 to 1960 , that (I) (we) last saw the deceased alive on Mar 6 1960, and that death occurred at 2:45 A.M. from the causes and on the date stated above.							
22a. SIGNATURE Frank R. Lewis				22b. DATE Nov. 7 / 1960		22c. PHYSICIAN'S NAME (Type) Dr. Frank R. Lewis	
22d. ADDRESS Willards, Maryland				22e. ADDRESS Willards, Maryland			
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE THEREOF Nov. 9, 1960		23c. NAME OF CEMETERY OR CREMATORY Wingo Cemetery - R.D.# Parsonsburg (Wingo) Md.		23d. LOCATION (City, town, or county) (State) Wingo, Maryland	
24. FUNERAL DIRECTOR'S SIGNATURE F. J. AY & COMPANY				25a. REC'D BY REGISTRAR NOV 9 '60		25b. REGISTRAR'S SIGNATURE William S. Kraus	



CERTIFICATE OF DEATH

Reg. Dist. No.

13215

1. PLACE OF DEATH a. COUNTY Wicomico MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE Maryland h. COUNTY Wicomico			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Salisbury				c. LENGTH OF STAY IN 1b 7 days			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Mt. Pleasant Nursing Home				e. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Allen, Md.			
				d. STREET ADDRESS 1			
3. NAME OF DECEASED (Type or print) First Essie Middle Parks Last Windsor				4. DATE OF DEATH Month Nov. Day 10 Year 1960			
5. SEX Female	6. COLOR OR RACE white	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH Aug. 5 1881	9. AGE (In years last birthday) yrs. 79	IF UNDER 1 YEAR Months Days Hours Min.		IF UNDER 24 HRS.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) none		10b. KIND OF BUSINESS OR INDUSTRY none		11. BIRTHPLACE (State or foreign country) Maryland		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME Robert Parks				14. MOTHER'S MAIDEN NAME Mary Davis			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) no		16. SOCIAL SECURITY NO.		17. INFORMANT Address Miss Rosa Windsor Allen, Md.			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) 331X cerebral hemorrhage DUE TO (b) generalized arteriosclerosis Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) Diabetes mellitus						INTERVAL BETWEEN ONSET AND DEATH 3 days ? yr.	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from June 28, 1960 , to November 10, 1960 , that I last saw the deceased alive on November 7, 1960 , and that death occurred at 2:10 PM , from the causes and on the date stated above.							
ACTUAL SIGNATURE Robt J. McKis M.D.				ADDRESS (Street, city or town, state) PRINCE ANNE, MD		DATE SIGNED Nov 11, 1960	
PHYSICIAN'S NAME (Type)							
22a. BURIAL, CREMATION, REMOVAL (Specify) burial		22b. DATE THEREOF 11-12-1960		22c. NAME OF CEMETERY OR CREMATORY Oriole Cemetery		22d. LOCATION (City, town, or county) (State) Oriole, Md.	
23. FUNERAL DIRECTOR'S SIGNATURE Levin R. Wilson				24a. REC'D BY REGISTRAR DATE NOV 14 '60		24b. REGISTRAR'S SIGNATURE Arthur L. Hume	

MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

CERTIFICATE OF DEATH

Form 100-101

<p>1. Name of deceased: <u>JOHN J. SMITH</u></p>	
<p>2. Sex: <u>Male</u></p>	
<p>3. Date of birth: <u>1915</u></p>	
<p>4. Place of birth: <u>NEW YORK</u></p>	
<p>5. Date of death: <u>1975</u></p>	
<p>6. Place of death: <u>HOME</u></p>	
<p>7. Cause of death: <u>HEART DISEASE</u></p>	
<p>8. Manner of death: <u>NATURAL</u></p>	
<p>9. Signature of physician: <u>[Signature]</u></p>	
<p>10. Signature of registrar: <u>[Signature]</u></p>	
<p>11. Date of registration: <u>1975</u></p>	
<p>12. Place of registration: <u>BALTIMORE</u></p>	
<p>13. Name of registrar: <u>[Name]</u></p>	
<p>14. Address of registrar: <u>[Address]</u></p>	
<p>15. Telephone number: <u>[Number]</u></p>	
<p>16. Name of hospital: <u>[Name]</u></p>	
<p>17. Address of hospital: <u>[Address]</u></p>	
<p>18. Telephone number: <u>[Number]</u></p>	
<p>19. Name of funeral home: <u>[Name]</u></p>	
<p>20. Address of funeral home: <u>[Address]</u></p>	
<p>21. Telephone number: <u>[Number]</u></p>	
<p>22. Name of cemetery: <u>[Name]</u></p>	
<p>23. Address of cemetery: <u>[Address]</u></p>	
<p>24. Telephone number: <u>[Number]</u></p>	
<p>25. Name of undertaker: <u>[Name]</u></p>	
<p>26. Address of undertaker: <u>[Address]</u></p>	
<p>27. Telephone number: <u>[Number]</u></p>	
<p>28. Name of coroner: <u>[Name]</u></p>	
<p>29. Address of coroner: <u>[Address]</u></p>	
<p>30. Telephone number: <u>[Number]</u></p>	

1
FOR STATE
HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If an autopsy is necessary, please execute the certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS. A15ME
5M 7/59

MARYLAND STATE DEPARTMENT OF HEALTH
Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND
13216 MEDICAL EXAMINER'S CERTIFICATE OF DEATH 13198

1. PLACE OF DEATH a. COUNTY Wicomico MARYLAND			2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) a. STATE Maryland b. COUNTY Wicomico		
b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) Salisbury			c. LENGTH OF STAY IN 10 Years		
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) Peninsula General Hospital			e. STREET ADDRESS Allen Perry Smiths Farm		
3. NAME OF DECEASED (Type or print) John Winston			4. DATE OF DEATH 11-11-60 19 19		
5. SEX M	6. COLOR OR RACE C	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH ?		9. AGE (In years last birthday) 70 yrs.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Labor		10b. KIND OF BUSINESS OR INDUSTRY Farming		11. BIRTHPLACE (State or foreign country) Georgia	
10c. FATHER'S NAME ?			12. CITIZEN OF WHAT COUNTRY? U.S.A.		
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) ?			16. SOCIAL SECURITY NO. ?		
17. INFORMANT Jackson Wallace, Allen, Md			Address		
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Coronary occlusion 420.1 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)					INTERVAL BETWEEN ONSET AND DEATH hours
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town)	(County)	(State)
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>					
ACTUAL SIGNATURE Earl L. Royer, M.D.		CHIEF MEDICAL EXAMINER <input type="checkbox"/>		DATE SIGNED 11-17-60	
EXAMINER'S NAME (Type) Earl L. Royer, M.D.		ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>		DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>	
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 11/15/60		22c. NAME OF CEMETERY OR CREMATORY Freind Ship	
23. FUNERAL DIRECTOR William H. James Jr. Princess Anne, Md		ADDRESS		24a. REC'D BY REGISTRAR NOV 21 '60	
24b. REGISTRAR'S SIGNATURE Arthur S. Frank		24c. LOCATION (City, town, or country) Allen, Maryland			

16516
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

10-11-11
10-11-11

Collected from _____

after _____

found in _____

11-11-11 _____

1

11-11-11 _____

11-11-11 _____